HEALTH SYSTEMS DIVISION
EDI Support Services

How to Complete the Oregon Medicaid Trading Partner Agreement (form #200-393903)

This guide is intended to be read in conjunction with the Oregon Medicaid Trading Partner Agreement (form #200-393903) form to help walk the user through completion of the application. If you have questions, please contact OHA.TPAgreements@odhsoha.oregon.gov

Definitions

Authorized Signer: A person responsible for business activities of the Trading Partner and authorized to sign binding agreements. This person must be with the provider (trading partner) and CANNOT be with a Billing Service.

EDI Submitter: An individual or entity authorized to conduct EDI (Electronic Data Interchange) transactions with OHA as a trading partner or agent of the trading partner as defined in Oregon Administrative Rule (OAR) 943-120- 0120.

Trading Partner: A Provider, Prepaid Health Plan (PHP), Coordinated Care Organization (CCO), clinic or allied agency as defined in Oregon Administrative Rule (OAR) OAR 943-120-0120.

Trade Relationship: A configuration which allows a transaction to be conducted by an EDI (Electronic Data Interchange) submitter on behalf of a Trading Partner.

Trading Partner: Submits a Trading partner Agreement (TPA) to authorize and establish the role(s) allocated to an EDI (Electronic Data Interchange) submitter. As necessary, the Trading Partner submits additional TPA when changes to registered transactions or their relationship to an EDI submitter have occurred.

EDI Submitter: Participates in business-to-business (B2B) testing with OHA. Once testing is completed, asks OHA for approval to move from testing to production. Manages password and log-on information. Conducts transactions.

Submission

Keep a copy of the completed, signed form for your records. Submit the form to OHA as a PDF document:

- **Email:** To OHA.TPAgreements@dhsoha.state.or.us
- **Fax:** To 503-947-2650

If you cannot submit by email or fax, you can mail forms to EDI Support Services,

500 Summer Street NE, E44, Salem, OR 97301

Walkthrough

Form Section	Instructions
Box at Top of page 1	This pop-out box should be completed with the National Provider Identifier,Taxonomies and Medicaid ID(s) (as registered with OHA) for which a Trading Partner wishes to authorize trade relationships. *Note: If you need to exchange transactions for more than one NPI, complete aTPA for each NPI.*

*Medicaid ID:	
*National Provider Identifier (NPI):	
*Taxonomy codes:	

Section 1	This section identifies the Trading Partner associated with the Medicaid ID listed at the top of the form. You should complete the fields of this section using information that matches the Trading Partner's current enrollment with OHA. If you have questions, contact Provider Services at 1-800-336-6016.

*****Section 1: Medicaid provider information – This page is to be completed and signed by the provider (*referred to as trading partner*) requesting this TPA.	
* **Business name**: (*as enrolled with OHA*)	
Physical address: (as enrolled with OHA)*	
*City, State and Zip:	
*Phone number with extension:	

Section 2	This section identifies the Trading Partner's authorized signer(s). This person will be (or has been) authorized to sign the completed TPA and any updates made to the TPA. Two Authorized Signers can be identified for each trade relationship. ***Note:** email addresses in all sections must be the individual listed direct email address only. Group emails are not allowed per HIPAA requirements. The phone number must be direct to the person listed. Add an extension, if needed.*

*****Section 2: Trading partner authorized signer information – The primary signer signs Section 6. The Primary Signer must be with the provider and CANNOT be from a Billing Service.	
***Primary authorized signer's name:**	
*Title:	
*Email Address: (*individual, not group email*)	
*Phone number with extension:	

***Secondary authorized signer's name:**	
*Title:	
*Email Address: (*individual, not group email*)	
*Phone number with extension:	

Section 3	This section identifies the Trading Partner's claims contacts. This person willbe authorized to contact OHA with questions on claims information. Contactslisted in this section may include billing services. ***Note:*** *email addresses in all sections must be the individual listed direct email address only. Group emails are not allowed per HIPAA requirements. The phone number must be direct to the person listed. Add an extension, if needed.*

***Section 3: Trading partner claims contact information –** List individuals and NOT groups.	
***Primary claims contact name:**	
*Phone number with extension:	
*Email address (*individual, not group email*)	
***** **Secondary claims contact name:**	
*Phone number with extension:	
*Email address (*individual, not group email*)	

Section 4	This section identifies the EDI Submitter which the Trading Partner wishes to authorize to exchange EDI transactions with OHA. For EDI Submitters that have already enrolled with OHA, include the Submitter Mailbox number. If the Trading Partner wishes to submit EDI transactions on their own behalf enter the Business Name (listed in Section 1) to be assigned as the submitter name and leave the Mailbox number field blank. We will assign an EDI mailbox number.

***Section 4: Electronic data interchange (EDI) Submitter Information –** • If your company intends to exchange transactions directly with OHA, enter the name (as listed in Section 1) as this will become the submitter name. • If you intend to use a submitter/clearinghouse, complete this part with their information.	
***Submitter or Clearinghouse name:**	
*Address:	
*City, State and Zip:	
*Submitter EDI mailbox number:	MB000 _ _ _

Section 5	A Trading Partner should select all transactions they wish to authorize the EDI Submitter listed in Section 4 to transact on their behalf.

*Section 5: Authorized transactions – Check all transactions that OHA should authorize for your EDI submitter.			
HIPAA 5010A1 transactions:			
	005010X222A1	**837P**	Professional claim submission
	005010X223A2	**837I**	Institutional claim submission
	005010X224A2	**837D**	Dental claim submission
	005010X221A1	**835**	Electronic remittance advice
	005010X279A1	**270 and 271**	Eligibility benefits inquiry and response
	005010X212	**276 and 277**	Claims status request and response
	005010X218	**820**	Group premium payments (*not available to all provider types*)
	Pharmacy carve-out		RX carve-out file
	Pharmacy 340B Drug Rebate		Pharmacy 340B Drug Rebate

Section 6	This section should include the Trading Partner Name listed in Section 1 and the contact information for the Primary Authorized Signer listed in Section 2 of this form.

*Section 6: Trading Partner Signature – By signing below, the Trading Partner certifies the following:

- I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at Secretary of State OAR rules website, and understand my responsibilities as stated in these rules.
- I authorize OHA to transmit to the EDI Submitter listed in Part Four (4) of this form the return computer file electronic vouchers of all transactions I have marked in Section Seven (5) of this form.

***Business name:** (as enrolled with OHA) (*from section one of this form*)	
*Email address: (*individual, not a group*)	
*Phone number with extension:	

*Authorized signer's printed name (person listed in Section 1) _____

*Authorized signer signature: _____ *Signature date: _____

Section 7	This section identifies contact information for the EDI Submitter. The Business Contact listed in this section will sign Section 8 of this form. If this agreement is being completed for an established EDI Submitter it is expected that the Business Contact listed match one of the EDI Submitter's authorized contacts as currently enrolled. An EDI Submitter's Technical Contact is the individual who will participate in any necessary testing. *Note: Enrolled EDI Submitters who need to update their contact information should contact DHS.EDISupport@dhsoha.state.or.us for assistance. Email addresses in this section may not include group addresses.*

*****Section 7: EDI Submitter Information – This page is to be completed and signed by the submitter or Clearinghouse that is chosen by the Medicaid provider. (Section 4).

Submitter name:_____ EDI mailbox number: MB000_ _ _

***Submitter business contact name:**	
*Phone Number with Extension:	
*Email address: (*individual, not group*)	
***Submitter technical contact name:**	
*Phone number with extension:	
*Email address: (*individual, not group*)	

Section 8	This section should include the Name and contact information of the EDI Submitter Business Contact listed in **Section Five** of this form.

Section 8: EDI Submitter Required Signature – **By signing below, the EDI Submitter certifies the following:**

- I have read the Electronic Data Transmission Oregon Administrative Rules (Chapter 943, Division 120) at Secretary of State OAR rules website, and understand my responsibilities as stated in these rules.
- •I agree to protect the confidentiality of the data as required by law.

***Submitter business name:** (*listed in Section 6*)	
*Email address: (*individual, not a group*)	
*Phone number with extension:	

*Authorized signer's printed name (person listed in Section 7) _____

*Authorized signer signature: _____ *Signature date: _____