

Payer Agreement Instructions for Dean Health Plan - 39113

Important Notes

The provider **must** be enrolled with the payer and have a valid Provider Identification Number (PIN) before completing the agreement to submit electronic claims. Please wait until the PIN has been assigned **before** completing these forms requesting submission of electronic claims. Please do not list the PIN as "pending".

To obtain a PIN for a specific payer, **the provider or Billing Service** must contact the payer's Provider Relations Department. Per-Se **cannot** make this request for the provider.

- If making copies include *all* pages of this agreement and be sure they are all legible.
- Submit one agreement for each Provider or Group ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 3- 4 weeks. If you receive an approval letter from the payer, contact us via phone or fax a copy to us. DO NOT transmit your claims until you receive an approval letter from Per-se or your claims will reject.

Guidelines for completing:

Dean Health Plan – Payer ID 39113

DHP Trading Partner Agreement

Field	Instructions
<i>Agreement/Addendum entered into on:</i>	<i>Enter day, month and Provider/Group Name</i>
<i>Name of Provider/Group (Please Print):</i>	<i>Self explanatory</i>
<i>Tax ID Number of Provider/Group:</i>	<i>Self explanatory</i>
<i>Name and Title of Provider/Group or Authorized Officer (Please Print):</i>	<i>Self explanatory</i>
<i>Signature & Date:</i>	<i>Sign and Date agreement (DHP will not process agreement without a valid signature and date)</i>
<i>DHP Authorized Agent (Please Print) Signature & Date:</i>	<i>Leave Blank</i>

EDI Set-Up Form

Field	Instructions
<i>Type of Practice/Group:</i>	<i>Select appropriate box</i>
<i>Type of Account:</i>	<i>Pre-filled by Per-Se</i>
<i>Transaction Type:</i>	<i>Pre-filled by Per-Se</i>

Contact Information

Field	Instructions
<i>Name, Address, City, State, Zip Office Manager Contact, Practice/Group Tax ID, Phone, Fax & Email Address:</i>	<i>Please provide all of the information requested</i>
<i>DHP Vendor Number:</i>	<i>This is your 6 digit alphanumeric assigned DHP vendor number</i>
<i>Confirmation Report Contact:</i>	<i>Complete this section if contact information is different than above</i>

Provider/Group Information

Field	Instructions
<i>Name of Provider/Group & Dean Health Plan Number:</i>	<i>Self explanatory</i>
Field	Instructions
<i>Payment Information (if different than above):</i>	<i>No information required for this field</i>
<i>If you are using a Clearinghouse:</i>	<i>Pre-filled by Per-Se</i>

Return the Agreement to the Payer via fax:

Fax Number

(608) 836-6335

Questions? Contact Per-Se enrollment at:

(800) 689-4550

Dean Health Plan Trading Partner Agreement

This agreement/addendum is entered into on this _____ day of _____, 2005 between Dean Health Plan (hereinafter referred to as DHP) and _____, (hereinafter referred to as Provider/Group) to submit data via electronic media. In signing this document, the Provider/Group is in full agreement to and follows all of the terms and conditions set forth.

This agreement provides the terms and conditions governing electronic transfers of data transmissions over communication lines accomplish the parties' business objectives.

Terms and Conditions

1. Transmission format. Provider/Group agrees to submit data edited and formatted for all standard transactions, as defined by Social Security Act § 1173(d) and any HHS implementing regulations or guidelines DHP shall be the final authority in resolving any discrepancies in how the electronic data shall be submitted.
2. National Standard Identifiers. DHP and Provider/Group will use National Standard Identifiers in all data transmissions conducted between the parties no later than DHP's compliance date with any National Standard Identifier adopted by HHS through regulations implementing the Health Insurance Portability and Accountability Act of 1996.
3. Testing. The Provider/Group must submit file(s) for testing before sending actual production files. NO production files will be accepted until written notification of file acceptance has been sent. Each test file will be checked for compliance to the HIPAA Implementation guides and must contain valid identification numbers for both the member and Provider/Group.
4. The undersigned Provider/Group understands that only one transaction type can be sent in a file. If more than one transaction type needs to be sent, separate files must be submitted.
5. Submission of Data. Each party will take reasonable care to ensure that the information submitted in each electronic transaction is timely, complete, accurate, and secure and will take reasonable precautions to prevent unauthorized access to (a) its own and other party's transmissions and processing systems, (b) the transmissions themselves, and (c) the control structure applied to transmissions between them.
6. Retransmission of Lost or Undecipherable Transmission. A party will retransmit the original transmission within 5 days of its discovery that a data transmission is lost or is an undecipherable transmission.
7. Backup Files. Each party will maintain adequate backup files, electronic tapes or other sufficient means to recreate a data transmission for at least six (6) years from the data transmission creation date.
8. Notices Regarding Formats. The parties shall provide the other party with at least thirty-one (31) days prior notice of implementation of any changes. All modifications to this Agreement must be made in writing signed by both parties.

9. Changes, no additions, no changes to meaning or intent. Provider/Group agrees that it will not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation (C.F.R. 162.915(a)), not add any data elements or segments to the maximum denied data set as proscribed in the HHS Transaction Standard Regulation (C.F.R. 162.915(b), or will not change the meaning or intent of any of the HHS Transaction Standard's implementation specifications (C.F.R. 162.915(d)).
10. Choice of Law. The interpretation and legal effect of this Agreement shall be governed by the laws of the State of Wisconsin.
11. By executing this Agreement below, the Provider/Group agrees to all of the terms and conditions of this Agreement.
- 12. The Provider understands that the submission of any electronic media claim to DHP is a claim for DHP payment and any misrepresentation or falsification of the records relating to that electronic claim is subject to prosecution under federal criminal and civil law and the laws of the State of Wisconsin and upon conviction, will result in fines and /or imprisonment.**
13. Confidentiality, Privacy and Security. DHP and the Provider/Group will conform with all appropriate federal and state laws and regulations pertaining to the confidentiality, privacy, and security applicable to each party.

Name of Provider/Group (Please Print)

Tax ID Number of Provider/Group

Name and Title of Provider/Group
or Authorized Officer (Please Print)

DHP Authorized Agent (Please Print)

Signature

Signature

Date

Date



EDI Set-Up Form

Type of Practice/Group:	Solo <input type="checkbox"/>	Group <input type="checkbox"/>	Hospital/Facility <input type="checkbox"/>	Billing Service <input type="checkbox"/>
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Type of Account:	New <input type="checkbox"/>	Existing (indicate changes below) <input type="checkbox"/>
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Transaction Type:	837 Institutional claim <input type="checkbox"/>	837 Professional claim <input type="checkbox"/>	837 Dental claim <input type="checkbox"/>
	835 Remittance <input type="checkbox"/>	834 Enrollment <input type="checkbox"/>	270/271 Eligibility <input type="checkbox"/>
	278 Referral Request and Response <input type="checkbox"/>		820 Premium Payment <input type="checkbox"/>

Contact Information:

Name: _____ DHP Vendor Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Manager Contact: _____ Practice/Group Tax ID: _____

Telephone: (____) _____ Fax: (____) _____

E-Mail Address _____

If sending an 837 transaction, please fill out the next section

Confirmation Report Contact: _____ Telephone: (____) _____

Mailing address (if different than above) to mail Confirmation Report/Rejected Claims report:

Provider/Group Information:

Name of Provider/Group	Dean Health Plan number

Payment Information (if different that above):

Name of Payee: _____ DHP Payee Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Payee Tax ID: _____

If you are using a Clearing House to submit your files, please fill out the next section

Clearing House Name: _____

Contact Person: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: (____) _____ E-Mail Address: _____