

Payer Agreement Instructions for South Dakota Medicaid - MC102

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. EDI Enrollment **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 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 McKesson EDI Enrollment or your claims will reject.

Guidelines for completing: South Dakota Medicaid - Payer ID MC102

Electronic Media Provider Agreement

Field	Instructions
<i>This agreement entered into by and between</i>	List Provider/Practice name

Provider

<i>Provider Type:</i>	Pre-filled by MedAvant
<i>How are you submitting</i>	Pre-filled by MedAvant
<i>Provider Name, Provider Number, Tax ID, Authorized Signature, Contact Person, Phone Number, Title & Date</i>	Complete this section in its entirety.

Software Provider or Billing Agency

NA	Pre-filled by MedAvant
----	------------------------

Mail Completed Form to Payer

Provider Enrollment
 Department of Social Services
 700 Governors Drive
 Pierre, SD 57501-2291

HOSPITAL, NURSING HOME/LTC, HCFA 1500, AND PHARMACY ELECTRONIC MEDIA PROVIDER AGREEMENT

Pursuant to Administrative Rule of South Dakota (67:16:35:05) this agreement is made and entered into by and between the Department of Social Services, State of South Dakota, also referred to as the "South Dakota Medical Assistance Program" and _____, also referred to as the "Provider". The purpose of this agreement is to enable the Provider to submit claims to the South Dakota Medical Assistance Program Agency with the use of electronic media.

It is hereby agreed as follows:

A. GENERAL PROVISIONS

1. This agreement will be automatically renewed for one year on July 1 if neither party gives notice requesting termination, except that the duration of this agreement may be limited pursuant to action by the South Dakota Medical Assistance Program in excluding a provider for fraud or abuse pursuant to 42 CFR Part 1002. This agreement may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party.
2. This agreement may be modified in writing by mutual consent of the South Dakota Medical Assistance Program and the Provider. Any such modification shall be attached to this agreement and become a part thereof.
3. The Provider must be an authorized medical assistance provider with a signed Standard Provider Agreement on file in order to enter into this agreement.
4. This agreement will in no way supersede the Standard Provider Agreement.

B. RESPONSIBILITIES OF THE PROVIDER/BILLING AGENT

1. Claims submitted by electronic media must comply with the format specifications defined by the South Dakota Medical Assistance Program. Failure to comply with the format specifications will result in the electronic claim being rejected.
2. The provider will notify the South Dakota Medical Assistance Program if the provider changes software providers or billing agents.

C. RESPONSIBILITIES OF THE SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM

If the above mentioned requirements are met the South Dakota Medical Assistance Program shall be responsible for the following:

1. The South Dakota Medical Assistance Program will process and reimburse the Provider in a timely manner for all covered services submitted via electronic media.
2. The South Dakota Medical Assistance Program will notify the Provider/Billing Agent of any changes that may occur in the format specifications.

PROVIDER

Provider Type: _____ HCFA _____ Hospital _____ Pharmacy _____ Nursing Home/LTC

How are you submitting? _____ Modem _____ POS _____ Launch Pad/Web Application

Provider Name (Typed)

Provider Number

Authorized Signature

Tax ID Number

Contact Person (Typed)

Telephone Number

Title (Typed)

Date

SOFTWARE PROVIDER OR BILLING AGENCY

Billing Agency or Software Name

Billing Agency or Software Number

Street Address

City, State and Zip Code

Contact Person (Typed)

Telephone Number

Electronic Remit _____ **YES** _____ **NO**

277 Claim Status Response _____ **YES** _____ **NO**

SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM

Authorized Signature

Larry Iversen

Name (Typed)

Division Director

Title (Typed)

Date