

**PROVIDER'S ELECTION TO EMPLOY ELECTRONIC MEDIA SUBMISSION OF CLAIMS
FOR PROCESSING IN THE LOUISIANA MEDICAL ASSISTANCE PROGRAM**

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Provider Number (7 digits)

Submitter Number (7 digits)
(Leave blank if applying for new number)

Provider Name: _____

Submission Medium:

TAPE ; DISKETTE ; TELECOMMUNICATIONS ;

Name of Billing Agent or Name of Provider if submitting own claims: _____

1. On the date of signature of this agreement, the undersigned elects and agrees to submit Louisiana medical assistance claims by means of the electronic media claims processing method in accordance with Paragraphs 1 through 13 below. This is done in consideration for the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing's (hereinafter referred to as "State Agency") processing of provider claims, as well as other valuable considerations.
2. All specifications set forth in the "Specifications for Submitting Claims" on Electronic Media Manual," and as amended, shall be met as to every entry sought to be processed. The submission medium is indicated above.
3. The Provider, or his agent, shall be responsible for total compliance with said specifications. The Provider's data processing agent for submission of medical assistance claims is indicated above and any changes in the Provider's data processing agent shall be preceded by 30 days written notice to the State Agency.
4. The Provider shall provide upon request of the director of the State Agency supportive documentation to ensure that all technical requirements are being met, i.e. program listings, tape or diskette dumps, flow charts, file descriptions, accounting procedures and the like.
5. The undersigned Provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the Provider, if electing a data processing agent to submit medical assistance claims directly, must give a legal power of attorney to that agent in order to sign each certification as part of a transmittal document which must accompany every medical assistance claims submission. A copy of the said certification statement is attached and is hereby incorporated by reference into this paragraph.
6. It is expressly understood that the State Agency or its Fiscal Intermediary (Unisys) may reject an entire submission at any time for failure to comply with the official specifications for submitting claims on electronic media or for any other reason.
7. The Provider agrees that this election does not in any way modify the requirements to the Policies and Procedures applicable to your provider type, except as the claims submission procedures which will be transmitted in electronic format rather than hardcopy.
8. The State Agency and the Provider mutually agree that this Agreement may be amended by mutual consent of the contracting parties. Such amendments must, however, be in writing and must be signed by the authorized representatives of contracting parties. This Agreement shall not be verbally amended.
9. The Provider agrees to submit to the State Agency, Fiscal Intermediary or any other authorized agent, upon request, sufficient documentation to substantiate the scope and nature of services provided for those claims submitted and for which reimbursement is claimed.
10. The Provider acknowledges and accepts responsibility for the provisions of Public Law 95-142 pertaining to fraud.
11. The Provider and the State Agency agree that each party to this Agreement shall have the right to unilateral termination of this Agreement upon delivery of written notice of termination upon the other party. The effective date of such termination shall be 30 days from the receipt of the notice of termination.

- 12. Further, for a period of five years, during the course of a federal/state audit or investigation, should documentation of the existence, nature and scope of the services pertaining to a medical assistance claim be requested, the Provider shall provide the documentation as requested or produce such for examination and copying.
- 13. The Provider agrees that this election shall be enforced in accordance with the laws of the State of Louisiana and that this election does not in any way modify the State Agency's limited obligations as set in a certain Provider Agreement between the State Agency and the Provider.
- 14. The Provider agrees to adhere to all requirements for submission and privacy as established under the Health Insurance Portability and Accountability Act (HIPAA) of 1996.

Print Name of Person Completing Form

Provider's/Authorized Agent's
Original Signature
(Stamps, initials not acceptable)

Date of Provider/Authorized Agent's Signature

Issuance of submitter number or linkage of third-party billing number denotes acceptance of this agreement by the Louisiana Department of Health and Hospitals.