Please return to:
Conduent EDI Solutions, Inc.
ATTN: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

Montana Conduent EDI Provider Enrollment Form Instructions

If a provider is submitting to Conduent EDI Solutions, Inc. and wishes to retrieve their own responses from the Host Data Exchange (HDE), the *Montana Conduent EDI Provider Enrollment Form* is to be completed. The provider does not need to complete the *Provider Billing Agent/Clearinghouse Conduent EDI Solutions, Inc. Authorization form.*

If a provider allows a billing agent/clearinghouse to submit and retrieve on their behalf, only the *Provider Billing Agent/Clearinghouses Conduent EDI Solutions, Inc. Authorization Form* is to be completed.

If a provider allows a billing agent/clearinghouse to submit transactions on their behalf, but the provider wishes to retrieve their own responses, including the 835 Remittance Advice, both the *Montana Conduent EDI Provider Enrollment Form* and the *Provider Billing Agent/Clearinghouses Conduent EDI Solutions, Inc. Authorization Form* should be completed.

The *Provider Billing Agent/Clearinghouses Conduent EDI Solutions, Inc. Authorization Form* precedes the *Montana Conduent EDI Provider Enrollment Form* in the attached document.

Instructions for completing the *Provider Billing Agent/Clearinghouses Conduent EDI Solutions, Inc. Authorization Form*

The *Provider Billing Agent/Clearinghouses Conduent EDI Solutions, Inc. Authorization Form* must be completed in its entirety and must include the signature of the provider or the provider's representative.

Section A. Provider Information

Please complete the demographic information. This is required.
Please enter your Federal Tax ID Number. A Group Provider should have the same Federal Tax ID Number for all providers it supports. This is required
Your email address is optional and will be kept confidential.

Section B. Authorization Signature (required)

Please complete with the appropriate information. If you are authorizing a billing agent/clearinghouse to retrieve your electronic responses, please check which responses you are authorizing for retrieval.

The provider or the provider's representative must print their name, sign their name, and date the form.

Please return to:
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PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

Please use the following instructions when completing the Montana Conduent EDI Provider Enrollment Form.

Section 1. Classification.
Please indicate whether you are an individual provider, a group provider, individual pharmacy, Branch Pharmacy, or corporate headquarters pharmacy. **This field is required.**

Section 2. Submission Method (This section is not applicable to pharmacies).
Please indicate how you will be submitting your electronic transactions. **This field is required.**

Section 3. Provider Information.
Please complete the appropriate provider information. **These fields are required.**
Please enter your Federal Tax ID Number. A Group Provider should have the same Federal Tax ID Number for all providers it supports. This is required
Your email address is optional and will be kept confidential.

Section 4. Montana Submitter ID.
If you are currently submitting electronic transactions to Montana FAS, please indicate your 7-digit submitter ID. This is your Montana DPHHS submitter ID assigned by FAS.

Section 4a. Submitter/Trading Partner ID.
If you are currently submitting electronic transactions to Conduent EDI Solutions, please indicate your 5-digit submitter ID or 6-digit trading partner ID.

Section 5. Contact Information.
Please indicate specific contact person and additional contact information, if different from the provider information in Section 3 above.

Section 6. Provider Using a Software Vendor, Billing Agent, or a Clearinghouse (This section is not applicable to pharmacies).
If you have indicated that you will be using Vendor Software, a Billing Agent, or a Clearinghouse, please complete section 6a.

WINASAP5010 users do not need to complete this section.

Sub-section 6b. Provider Using a Software Vendor.
If you have indicated that you are a provider and plan to submit transactions with vendor software, please complete the following field.

Sub-section 6c. Submitter/Trading Partner ID Number.
If your Software Vendor/Billing Agent/Clearinghouse is currently submitting electronic transactions directly to Conduent EDI Gateway, please indicate their Conduent 5-digit submitter ID or 6-digit Trading Partner ID. You may need to contact your Software Vendor/Billing Agent/Clearinghouse for this information.

Please return to:
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PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

Section 7. Transactions Available for Transmission (This section is not applicable to pharmacies).

If you will be using the WINASAP5010 product, please complete section 7a. If you will be submitting electronic transactions other than WINASAP5010 submissions, please complete section 7b.
Nursing Facility Providers: Choose Transaction 837I (Institutional)

Sub-Section 7a. WINASAP5010 (Replacing ACE$ Software).

Request for software.
Please indicate how you would like to receive the software and which transactions you will be submitting.

Sub-Section 7b. Standard Transactions (Submissions other than WINASAP5010).

If you will be submitting transactions other than WINASAP5010 transactions, please complete this section. **Providers submitting through a Software Vendor, Billing Agent, or Clearinghouse must complete this section.**

Section 8. Delimiter Information (This section is not applicable to pharmacies).

If you will be submitting X12N transactions directly to Conduent, please indicate the alternate delimiter to be used if you are not using the default. **WINASAP5010 users do not need to complete this section.**

Section 9. Electronic Response Retrieval.

Montana Providers will be able to retrieve responses via the Host Data Exchange (HDE). If you would like to participate in this service, please indicate which responses you would like to retrieve via HDE.
If you are a pharmacy the only available response available to you is the X12N 835 (Payment Advice)

** Business Service Agreement

Section 10. Additional Provider List.

If you are submitting transactions on the behalf of multiple providers, please supply the provider name and provider number of each additional provider. If you have more than twenty-five (25) providers please contact Conduent EDI Enrollment for further instructions at the phone number listed below.

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

Please return to:
Conduent EDI Solutions, Inc.
Attn: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

Provider Billing Agent/Clearinghouse Conduent EDI Solutions, Inc Authorization Form

Section A. Provider Information.	
Business Name	
Provider Name (Last, First, MI and Suffix)	
Provider Number	*Federal Tax ID Number*
Business Address	
City, State, and Zip	
Telephone Number	*Fax Number*
Contact Name	*E-mail Address*

Section B. Authorization Signature *(required).*

Provider, _____ hereby appoints

Provider name /Provider Representative name (please print)

_____, _____

Billing Agent/Clearinghouse name (please print) *Billing Agent/Clearinghouse Conduent Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting health care transactions electronically to Conduent EDI Solutions, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- ☐ 277-Claim Status Response
- ☐ 835-Healthcare Claims Payment Advice
- ☐ Exception Report (Print Image)
- ☐ 277CA-Healthcare Claim Acknowledgement
- ☐ 271-Eligibility Response
- ☐ 278-Prior Authorization Response
- ☐ 999-Implementation Acknowledgement

_____

Provider/Provider Representative name (Please print)

_____ _____

Provider/Provider Representative Signature *Date*

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

Please return to:
Conduduent EDI Solutions, Inc.
Attn: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

EDI PROVIDER ENROLLMENT FORM. Please print or type. Complete all areas of the Provider Enrollment Form, unless otherwise indicated.

Section 1. Classification. Please indicate your classification.

☐ **Individual Provider** ☐ **Group Provider**

☐ **Individual Pharmacy** ☐ **Branch Pharmacy** ☐ **Corporate Headquarters Pharmacy**

Section 2. Submission Method. Please indicate how you plan to submit your electronic transactions. (This section is not applicable to Pharmacies)

☐ **Asynchronous (Direct Submission to EDI)** ☐ **WINASAP5010** ☐ **Vendor Software**

☐ **Billing Agent** ☐ **Clearinghouse**

Section 3. Provider Information.

Business Name (If applicable)	
Provider Name (Last, First, MI, and Suffix)	
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Provider Number (Required for Individuals)	*Federal Tax ID Number*
Email Address (If applicable)	

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

Please return to:
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Attn: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

Section 4. Montana Submitter ID.	
If you are currently submitting electronic transactions directly to Montana FAS, please indicate your Montana 7-digit Submitter ID: **NOTE: This is your Montana DPHHS Submitter ID Assigned by FAS.**	☐☐☐☐☐☐☐

Section 4a. Submitter/Trading Partner ID Number.	
If you are currently submitting electronic transactions directly to Conduent EDI Solutions, please indicate your Conduent EDI Solutions 5-digit Submitter ID or 6-digit Trading Partner ID: **NOTE: This is NOT your Montana submitter ID**	☐☐☐☐☐☐

Section 5. Contact Information. Please indicate contact information.	
Contact Name	*Contact Title*
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Email Address	

Additional Contact Information. Please indicate additional contact information.	
Contact Name	*Contact Title*
Business Street Address	
City, State, and Zip Code	
Telephone	*Fax*
Email Address	

Please attach additional sheets if necessary.

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

Please return to:
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PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

Section 6. Provider Using a Software Vendor, Billing Agent, or a Clearinghouse.
If you have indicated that you plan to use Vendor Software, a Billing Agent, or a Clearinghouse to submit your transactions electronically to Conduent EDI Solutions, please provide the following information.
(If you plan on using WINASAP5010, you do not need to complete this section.)

Sub-section 6a. Type of Service that you use.

Please indicate the type of service that you use to submit electronic transactions.
(This section is not applicable to Pharmacies)

☐ **Software Vendor (SV)** ☐ **Clearinghouse (CH)** ☐ **Billing Agent (BA)**

SV/CH/BA Name			
Contact Name		***Contact Title***	
Business Address			
City, State, and Zip Code			
Telephone Number		***Fax Number***	
Email Address			

Sub-section 6b. Provider Using a Software Vendor.

If you plan to use Vendor Software, please complete the following information related to your software.

Software Name:		**Software Version:**		**Protocol:**	

Sub-section 6c. Software Vendor, Billing Agent or Clearinghouse Submitter ID or Trading Partner ID.

Note: Your Software Vendor, Billing Agent or Clearinghouse must be equipped with their own uniquely assigned Conduent EDI Solutions Submitter ID or Trading Partner ID to act on your behalf. Please contact your Software Vendor, Billing Agent/Clearinghouse to confirm their status with Conduent EDI.

Please indicate your Software Vendor/Clearinghouse/ Billing Agent's Conduent 5-digit Submitter ID or 6-digit Trading Partner ID: **NOTE: This is not your 7-digit Montana submitter ID assigned by FAS**	☐ ☐ ☐ ☐ ☐ ☐

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

Please return to:
Conduent EDI Solutions, Inc.
Attn: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

Section 7. Transactions Available for Transmission. (This section is not applicable to pharmacies)

Sub-Section 7a. WINASAP5010 (replacing WINASAP2003).

Request for free WINASAP5010 Software:

☐ I will download a copy from the Conduent website at http://medicaidprovider.mt.gov/claims

☐ X12N 837P (Professional Claim)	☐ X12N 837D (Dental Claim)
☐ X12N 837I (Institutional Claim)	

Sub-Section 7b. Standard Transactions. Check all that apply (Submissions other than WINASAP5010)

☐ X12N 837P (Professional Claim)	☐ X12N 278 (Prior Authorization)
☐ X12N 837D (Dental Claim)	☐ X12N 270 (Eligibility Inquiry)
☐ X12N 837I (Institutional Claim)	☐ X12N 276 (Claim Status Inquiry)

Section 8. Delimiter Information. If you are submitting X12N transactions directly to Conduent, please provide please provide an alternate delimiter if you are not using the default.
(This information is not required for users of WINASAP5010 and not applicable to pharmacies)

Element Delimiter to be used: ☐	Segment Delimiter to be used: ☐	Sub-Element Delimiter to be used: ☐
Default Delimiter (asterisk) *	*Default Delimiter (tilde)* ~	*Default Delimiter (colon)* :

Section 9. Electronic Response Retrieval. Check all that apply

All Montana providers can retrieve their electronic responses from Host Data Exchange (HDE). If you would like to participate in this service, please complete the section below.

Responses available for X12N Transactions.
(If you are a pharmacy your only valid selection is the X12N 835 Healthcare Claim Payment/Advice)

☐ X12N 999 (Implementation Acknowledgement)	☐ X12N 835 (Healthcare Claim Payment/Advice)
☐ X12N 271 (Eligibility Response)	☐ X12N 277 (Claims Status Response)
☐ X12N 278 (Prior Authorization Responses)	☐ X12N 277CA (Healthcare Claim Acknowledgement)

☐ Exception Report (Print Images) ** If you have selected this option you must complete the Business Associate Agreement (BAA). Please call 1.800.987.6719 to request the BAA be faxed or mailed to you or go to http://medicaidprovider.mt.gov and download the form. You may fax or mail this form to Conduent EDI Solutions.

MONTANA DPHHS EDI PROVIDER ENROLLMENT FORM

Please return to:
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Attn: MT EDI
PO Box 4936
Helena, MT 59604
Or fax to 406-442-4402

Section 10. Additional Provider/Pharmacy List

Provider/Pharmacy Name	Provider/NCPDP ID (NABP)

Please attach additional sheets if necessary

CONDUENT EDI SOLUTIONS, INC.
TRADING PARTNER AGREEMENT

THIS TRADING PARTNER AGREEMENT ("Agreement") is by and between **TRADING PARTNER** ("Trading Partner") and CONDUENT EDI SOLUTIONS INC. ("EDI Gateway") collectively "the parties".

WHEREAS, Trading Partner desires to transmit Transactions to EDI Gateway for the purpose of submitting data to a Health Plan;

WHEREAS, EDI Gateway desires to receive such transactions for this purpose recognizing the EDI Gateway performs such services on behalf of the Health Plan; and

WHEREAS, Trading Partner is subject to the Transaction and Code Set Regulations with respect to the transmission of such transactions.

Now, therefore, the Parties agree as follows:

1. Definitions

EDI Gateway means Conduent EDI Solutions, Inc.

Trading Partner means the party identified as "Trading Partner" on the signature line of this Agreement who is a Health Care Provider or Health Care Clearinghouse as defined in 45 CFR 160.103.

Standard is defined in 45 CFR 160.103.

Transaction and Code Set Regulations means those regulations governing the transmission of certain health claims transactions as published by DHHS under HIPAA.

2. Obligations of the Parties Effective Upon Execution of this Agreement by Trading Partner

A) The Parties agree, in regard to any electronic Transactions between them:

1) They will exchange data electronically using only those Transaction types as selected by Trading Partner on the Conduent EDI Solutions Trading Partner Enrollment Form (TPEF).

2) They will exchange data electronically using only those formats (versions) as specified on the TPEF.

3) They will not change any definition, data condition, or use of a data element or segment in a Standard transaction they exchange electronically.

4) They will not add any data elements or segments to the Maximum Defined Data Set.

5) They will not use any code or data elements that are not in or are marked as "Not Used" in a Standard's implementation specification.

6) They will not change the meaning or intent of a Standard's implementation specification.

7) EDI Gateway may reject a Transaction submitted by Trading Partner if the Transaction is not submitted using the data elements, formats or Transaction types set forth in the TPEF. EDI Gateway may refuse to accept any claims from Trading Partner if Trading Partner repeatedly submits Transactions that do not meet the criteria set forth in TPEF or if Trading Partner repeatedly submits inaccurate or incomplete Transactions to EDI Gateway.

B) Trading Partner understands that EDI Gateway or others may request an exception from the Transaction and Code Set Regulations from DHHS. If an exception is granted, Trading Partner will participate fully with EDI Gateway in the testing, verification, and implementation of the modification to a Transaction affected by the change.

C) EDI Gateway understands that DHHS may modify the Transaction and Code Set Regulations. EDI Gateway will modify, test, verify, and implement all modifications or changes required by DHHS using a schedule mutually agreed upon by Trading Partner and EDI Gateway.

D) Neither Trading Partner nor EDI Gateway accepts responsibility for technical or operational difficulties that arise out of third party service providers' business obligations and requirements that undermine Transaction exchange between Trading Partner and EDI Gateway.

E) Trading Partner and EDI Gateway will exercise diligence in protection of the identity, content, and improper access of business documents exchanged between the two parties. Trading Partner and EDI Gateway will make reasonable efforts to protect the safety and security of individually assigned identification numbers that are contained in transmitted business documents and used to authenticate relationships between the parties.

EDI Gateway may publish data clarifications ("Conduent Companion Guides") to complement each Implementation Guide. Trading Partner should use Conduent Companion Guides in conjunction with the HIPAA Implementation Guides available at http://store.x12.org/store/healthcare-5010-consolidated-guides.

F) Transactions are considered properly received only after accessibility is established at the designated machine of the receiving party. Once transmissions are properly received, the receiving party will properly transmit an electronic acknowledgement that conclusively constitutes evidence of properly received transactions. Each party shall use commercially reasonable efforts to ensure that a Virus is not sent to the other party. Each party agrees that it maintains anti-virus software on its system, which is updated on a regular basis. For the purposes of this Agreement, "Virus" shall mean any "back door", "time bomb", "Trojan horse", "worm", "drop dead device", "virus", "malicious logic", software routines, devices, computer codes, program or hardware components or other undisclosed feature or file which is designed to permit unauthorized access to software, hardware or data, unintentionally or intentionally disrupts, disables, harms, erases, or otherwise impedes the other party's systems, or would disable such software or technology.

G) Each party will implement and maintain appropriate policies and procedures and mechanisms to protect the confidentiality and security of PHI transmitted between the parties.

H) The parties acknowledge that any person, who knowingly and with intent to defraud an insurance company or other person, files a statement of claim containing materially false information or conceals, with intent to mislead, information concerning any fact material to a statement of claim, commits a fraudulent insurance act, which may involve violations of civil and/or criminal law.

3. Miscellaneous

A) This Agreement is effective on the date set forth in Section 3.H, below. This Agreement shall continue until such time as either party elects to give reasonable written notice of termination to the other party or termination of Transaction services provided by EDI Gateway to Trading Partner, whichever is earlier.

B) This Agreement incorporates, by reference, any written agreements between the parties relating to the subject matter hereof.

C) This Agreement shall be interpreted consistently with all applicable federal and state privacy laws. In the event of a conflict between applicable laws, the more stringent law shall be applied. This Agreement and all disputes arising from or relating in any way to the subject matter of this Agreement shall be governed by and construed in accordance with New York law, exclusive of conflicts of law principles. THE EXCLUSIVE JURISDITION FOR ANY LEGAL PROCEEDING REGARDING THIS AGREEMENT SHALL BE IN THE COURTS OF THE STATE OF New York AND THE PARTIES HEREBY EXPRESSLY SUBMIT TO SUCH JURISDICTION.

D) Unless otherwise prohibited by statute, the parties agree that this Agreement shall not be affected by any state's enactment or adoption of the Uniform Computer Information Transaction Act, Electronic Signature or any other state or federal law. Each party agrees to comply with all other applicable state and federal laws in carrying out its responsibilities under this Agreement. This Agreement shall not be construed as to impute the application of any law onto a party or require compliance by a party, if such law does not already apply to or require compliance by the party, including but not limited to, the designation of a party as a "covered entity" under HIPAA if such status does not already apply under the law.

E) This Agreement is entered into solely between, and may be enforced only by Trading Partner and EDI Gateway. This Agreement shall not be deemed to create any rights in third parties or to create any obligations of Trading Partner or EDI Gateway to any third party.

F) NO WARRANTIES, EXPRESS OR IMPLIED, ARE PROVIDED BY EDI GATEWAY UNDER THIS AGREEMENT. EDI GATEWAY'S MAXIMUM AGGREGATE LIABILITY FOR

DAMAGES FOR ANY AND ALL CAUSES WHATSOEVER ARISING OUT OF THIS AGREEMENT, REGARDLESS OF THE MANNER IN WHICH CLAIMED OR THE FORM OF ACTION ALLEGED, IS LIMITED TO THE AMOUNT(S) PAID TO EDI GATEWAY BY TRADING PARTNER UNDER THIS AGREEMENT.

G) EDI Gateway may provide proprietary software to Trading Partner to allow Trading Partner to submit transactions to EDI Gateway. Trading Partner will protect the software as it protects its own confidential information, but in no event shall this protection be less than pursuant to a reasonable standard, and will not directly or indirectly, allow access to or the use of the software or any portion thereof, on any computer, server, or network, by any person, corporation, or business entity other than Trading Partner. Trading Partner may permit use of the software by contractors or agents of Submitter provided that any such contractor or agents are not competitors of EDI Gateway and further provided that any such persons agree to protect the confidentiality of the software. Trading Partner and its contractors and agents are not permitted to use the software for any purpose other than submitting Transactions solely to EDI Gateway.

H) Trading Partner may elect to execute either a hard copy or an electronic copy of this Agreement. Hard Copy Execution: Trading Partner will sign a hard copy of this Agreement and mail to EDI Gateway at the address indicated below. EDI Gateway will return a copy of the fully executed Agreement to Trading Partner. The effective date of the hard copy Agreement is the date on which the Agreement is signed by EDI Gateway. Electronic Copy Execution: Trading Partner should execute this Agreement by clicking on the "I Agree" button that appears at the bottom of the Agreement. The effective date of the electronic copy agreement is the date EDI Gateway receives the electronic transmission of Trading Partner's Acceptance to the terms of this Agreement.

TRADING PARTNER

_____
NPI/API

_____Date:_____
Signature

_____
Printed Name and Title

_____
Address

_____

PROVIDER ENROLLMENT
P.O. Box 4936
Helena, MT 59604

DPHHS-MA-098 (Rev. 05/2011)

State of Montana
Department of Public Health & Human Services
Medicaid Services

ELECTRONIC BILLING AGREEMENT

(Provider Name) _____ (Billing ID) _____

(Provider Street Address) _____ (City, State, Zip Code) _____

The undersigned provider hereby elects to submit claims by electronic means to the Montana Department of Health and Human Services medical assistance programs in accordance with the provisions stated herein.

The provider agrees that this election does not in any way modify the requirements of the policies and procedures for services, the Montana Medicaid Provider Enrollment Form or any other contract or agreement with the Department, except as to claim submission methods.

Amendments must be in writing and must be signed by the authorized representative of the contracting parties. This agreement shall not be verbally amended.

The provider and the department agree that each party to this agreement shall have the right to unilateral termination of their agreement upon delivery of written notice of termination of the other party.

The provider and/or his intermediary shall provide, upon the request of the state, supportive documentation to ensure that all technical requirements are being met. Examples of supportive documentation include, but are not limited to, program listing, tape dumps, flow charts, file descriptions, accounting procedures and the like.

The provider shall continue to be ultimately responsible for the accuracy and truthfulness of all medical assistance claims submitted for payment. Nevertheless, the provider, if he selects a data processing agent to submit medical assistance claims directly, authorizes the agent to act for the provider to submit claims on the provider's behalf. The provider acknowledges that their agent's submission of the provider's medical assistance claims to the department is on the provider's behalf, and is responsible for the truth, accuracy, and completeness of the claims submitted.

The provider agrees to submit to the Montana Department of Public Health and Human Services or its 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.

The provider shall provide all documentation requested during the course of a federal or state audit or investigation, concerning the nature, scope or existence of the services pertaining to a medical assistance claim. Should the provider fail to provide such documentation, the provider shall remit to the department the amount previously paid pertaining to the claim for which documentation has been requested. Should such remittance to the department not be made within thirty (30) days after a written demand is made therefore, the department is hereby authorized by the provider to deduct that amount from any amounts which may otherwise be due or become due to the provider.

Requirements for retention of source documents are as follows:

If claim information is transmitted to the intermediary by paper, either the intermediary or the provider must maintain the documents transmitted in accordance with department rules for records retention. Microfilm or microfiche copies may be maintained in place of original documents provided they meet the requirements defined in the Montana Records Management Policies and Procedures.

If claim information is transmitted electronically to the intermediary, the intermediary must maintain the tape, microfilm or microfiche containing the claim information in accordance with department rules for record retention.

The provider acknowledges that the following provider's certification statement, under which he endorses warrants in payment of medical assistance, applies to all services he provides regardless of the method of submission to the Department of Public Health and Human Services:

I understand "That Endorsement" hereon or deposit to the accounts of the within payee is done with the understanding that payment will be from federal and state funds and that any false claims, statements or documents, or concealment of a material fact may be prosecuted under applicable federal and state law.

The provider certifies that the services billed for will have been provided without regard to race, color, national origin, creed, sex, religion, political ideas, marital status, age or handicap.

The provider agrees to furnish to the department's claim processing agent copies of the written agreements with any intermediary that has been authorized to submit medical assistance claims in the provider's behalf.

The provider agrees that billing services and compensation for such will be related to the cost of processing the billing and acknowledges that it may not be related on a percentage or other basis to the amount that is billed or collected and may not be dependent upon the collection of that payment required by federal regulation or this agreement.

The provider agrees that any intermediary that has been authorized to establish receivables and make collections in their behalf shall have an effective system for identifying duplicate payments from other sources (third party) so as to ensure the Montana Department of Public Health and Human Services medical assistance programs' standing ass the payer of last resort.

The provider agrees to require any intermediary they contract with to process medical assistance claims to send to the provider, at least monthly, a complete listing of claims processed in their behalf by the intermediary that identifies, at a minimum, the following: 1) patient name, 2) patient medical assistance ID number, 3) date of service, 4) service/procedure, 5) charged amount, 6) all payments,* 7) payment sources.* [Required only when an intermediary is contracted to establish receivables and make collections.] The provider agrees to personally review these reports.

All specifications set forth in the department's, "Electronic Billing Specifications," as from time to time amended, shall be met for every entry submitted. A copy of such procedures may be requested at any time fromConduent Provider Relations. The department agrees to supply the provider with any amendments to these specifications within a reasonable time prior to the time such amendments or changes to the procedures shall go into effect.

It is expressly understood that the department may reject an entire submission at any time for failure to comply with the "Electronic Billings Specifications" as in effect pursuant to the above paragraph or for any other valid reason.

The provider agrees to the obligation of researching and correcting any and all claim discrepancies caused by the provider or their contracted intermediary.

The provider understands that participation in the Montana medical assistance program(s) issubject to compliance with this agreement and Federal and State laws and regulations. Non-compliance is cause for termination of this agreement.

Signed this_____day of_____, 20_

_____
(Provider Signature)

Distribution : Original to Conduent EDI Solutions, Inc., ATTN: MT EDI, P.O. Box 4936, Helena, MT, 59604 or fax to (406) 442-4402
Copy retained by Provider