Electronic Data Interchange Agreement

DO NOT FAX

ALL ATTACHED FORMS MUST BE SENT BY
(1) UPLOADING THEM ON THE PORTAL OR (2) MAIL TO TMHP.

(1) UPLOAD ALL ATTACHED FORMS TO:
www.tmhp.com/contact
Select the 'Email Us' button and choose 'LTC EDI Agreement' in the 'Subject' dropdown.
Fill out all required fields, attach the forms, and click 'Submit.'

(2) MAIL ALL ATTACHED FORMS TO THE FOLLOWING ADDRESS:
Texas Medicaid & Healthcare Partnership
Attention: EDI Help Desk, MC–B14
PO Box 204270
Austin, TX 78720-4270

Your request for access to Electronic Data Interchange cannot be approved until all forms have complete, accurate information with an original signature if the forms are sent by mail, or an electronic signature if the forms are uploaded on the portal. Under no circumstances will TMHP accept faxed agreements, emailed agreements received not by the path specified (1) above, or agreements with photocopied signatures.

DO NOT FAX

Dear Provider:

The Texas Medicaid & Healthcare Partnership (TMHP) welcomes your interest in its electronic services for Long Term Care (LTC) providers. The use of TMHP electronic services helps providers get claims paid faster, more accurately, and with less effort from their office staff. Providers can use high-speed Internet connections (e.g., DSL, cable modem, T1) to connect to TMHP's electronic services, which include eligibility verification, claims submission, claim status inquiry, American National Standards Institute (ANSI) 835 Remittance and Status Reports, and adjustments.

TMHP requires all LTC providers to complete the Electronic Data Interchange (EDI) Agreement before they can begin to submit or retrieve electronic files. This agreement includes all new providers, changes of ownership, name changes, and Intermediate Care Facility for Individuals with an Intellectual Disability or Related Conditions (ICF/IID).

The EDI Agreement must be complete, accurate, and contain original signatures if the forms are sent by mail or electronic signatures if the forms are uploaded on the portal. All EDI Agreements must be sent by either (1) uploading them on the portal or (2) mail to TMHP. Providers may use U.S. Mail, UPS, or any other package service to send the agreement to TMHP. *Under no circumstances will TMHP accept faxed, emailed agreements not received by the path specified in option (1) above, emailed agreements, or agreements with photocopied signatures.*

For questions about the EDI Agreement, please contact the EDI Helpdesk at 888-863-3638. For questions about the information that is on file with the State of Texas used to verify the agreement, please contact the contract manager.

Upload all attached forms to:
www.tmhp.com/contact
Select the 'Email Us' button, choose 'LTC EDI Agreement' in the 'Subject' dropdown.
Fill out all required fields, attach the form, and click 'Submit.'

Mailing Address—U.S. Mail
Texas Medicaid & Healthcare Partnership
Attention: EDI Helpdesk, MC-B14
PO Box 204270
Austin, TX 78720-4270

Mailing Address—Package Services
Texas Medicaid & Healthcare Partnership
Attention: EDI Helpdesk
12365-A Riata Trace Pkwy., Ste. 100
Austin, TX 78727

Telephone
888-863-3638

Website
www.tmhp.com

Getting Started With Electronic Services

EDI Agreement

All LTC providers must submit and complete an accurate copy of the agreement with original signatures if the forms are sent by mail, or electronic signatures if the forms are uploaded on the portal, before TMHP can grant access to any electronic services. A separate agreement must be completed for each provider number. The EDI Agreement consists of three parts—two copies of the Electronic Data Interchange Agreement and one copy of the Request for Electronic Services.

The EDI Agreement authorizes providers to submit claims electronically to TMHP. The agreement serves as a legal certification that all claims submitted electronically are accurate and that the provider assumes responsibility for maintaining the necessary records.

The Request for Electronic Services gathers the information necessary to validate the provider's identity, authorize electronic services, and allow access to the system. Once the agreement has been validated and processed, one copy of the EDI Agreement is returned to the provider with the signature of the provider and a TMHP representative. TMHP keeps the second signed copy of the agreement and the Request for Electronic Services form for its records. The provider may begin to submit and retrieve electronic files once they receive the TMHP signed copy of the agreement.

Software

Providers that intend to use TMHP electronic services will need software to create, submit, and retrieve data files. The software can be from any vendor listed on the Approved Vendor List on the EDI web page, which providers can view by going to **www.tmhp.com/sites/default/files/file-library/edi/5010 Approved Vendors.pdf**. Providers who plan to use a billing agent (i.e., billing companies, vendors, or clearinghouses) to submit EDI transactions to TMHP, should contact that organization for details on software requirements.

Vendor Software

Providers may use vendor software to access TMHP electronic services. There are hundreds of vendors with a wide assortment of services that have been approved to submit electronic files to TMHP. Providers can view a complete list of vendors who have completed the testing process and been certified by TMHP by going to **www.tmhp.com/sites/default/files/file-library/edi/5010 Approved Vendors.pdf**.

TMHP does not make vendor recommendations or provide any assistance for vendor software. Not all vendor software offers the same features or levels of support. Providers are encouraged to research their software thoroughly to make certain it will meet their needs and that it has completed testing with TMHP.

TexMedConnect

The TexMedConnect Long Term Care application is accessed online on the TMHP website at **www.tmhp.com**. TexMedConnect delivers an integrated, web-based application, provides a stable and secure environment for claims submission as well as accessibility from any computer with Internet access.

To access or to learn more about TexMedConnect visit **www.tmhp.com** or call the EDI Helpdesk at 888-863-3638.

Billing Agents

Billing agents are companies or individuals who submit electronic files to TMHP on behalf of the provider. Using a billing agent means that the provider uses a product that sends billing or other information to the billing agent who processes it and then transmits it to TMHP and other institutions.

TMHP has no information on the software or other requirements of billing agents. Providers should contact the billing agent to obtain information about their products and processes and to obtain their Submitter ID to complete the Request for Electronic Services. TMHP will never give out a billing agent's Submitter ID.

Providers can view a complete list of billing agents who have completed the testing process and been certified by TMHP by going to **www.tmhp.com/sites/default/files/file-library/edi/5010 Approved Vendors.pdf**.

TMHP does not make billing agent recommendations or provide any assistance for billing agents' software or services.

ANSI 835 Remittance and Status Reports

The ANSI 835 report is available electronically to billing providers itemizing claims submissions, claims dispositions, and warrant information. Providers who use electronic services can download the electronic version of the ANSI 835 report. This report can be accessed by selecting "ANSI 835" from the left navigation panel located within TexMedConnect. The EDI Agreement will automatically set up the provider to have access to the report with the Submitter ID indicated in the Request for Electronic Services. Only one Submitter ID can download the ANSI 835 report. Based on the provider's security permissions, the R&S Reports may also be accessed in an Adobe® PDF version by selecting "R and S" from the left navigation panel located within TexMedConnect.

If providers wish to change their R&S Report delivery method, they may complete the Submitter ID Linking Form that designates the Submitter ID they would like to use. Providers can access the form from the EDI Forms web page at **www.tmhp.com/resources/forms?field_topics_target_id=96** or by contacting the EDI Helpdesk at 888-863-3638.

Electronic Data Interchange Agreement

On this ____________________ Texas Medicaid & Healthcare Partnership, hereinafter called "Contractor,"
Date

and ____, ________________________,
*Legal Name of Provider including DBA** *Provider Number**

hereinafter called "Provider," enter into the following agreement. WHEREAS, Contractor processes claims for Long Term Care programs, hereinafter called "LTC" in the State of Texas; WHEREAS, Provider desires to submit claims for reimbursement under one or more of the LTC programs in a machine readable form via electronic media; NOWTHEREFORE, Contractor and Provider agree between and among each of them as follows:

I. Contractor agrees to accept from Provider (or from any billing agent Provider employs) electronic claims for reimbursement under the Texas Health and Human Services LTC programs and process such claims in the same manner as it would process claims submitted by Provider on the appropriate paper claim form, but only upon and subject to the terms and conditions of this Agreement.

II. Provider agrees:

A. That all electronic claims submitted by Provider or Provider's billing agent will:

1. Be in a format acceptable to Contractor for the program(s) involved.
2. Be submitted in accordance with Contractor's electronic claims billing procedures.
3. Contain all information required by Contractor.

B. That no claims that require individual consideration will be submitted through the electronic claims process, including, but not limited to, claims requiring supporting documentation.

C. That Provider has complied with the contractual and licensure requirements, laws and regulations of the various state and federal agencies, and conditions that would allow Provider to participate in and receive reimbursement under the LTC program(s) for which claim is made.

D. That electronic claims submitted to Contractor by Provider or by any billing agent Provider might choose to employ shall contain true, accurate, and complete information.

E. Provider will review for accuracy claims payment information from claims processed by Contractor. Provider may request an adjustment of a payment decision from the Contractor within the requisite number of days for the appropriate program under which the claim was filed.

F. The cashing of each warrant or receipt of direct deposit for claims paid to Provider will be a representation and certification that Provider presented the bill for the services shown on the accompanying explanation of payment forms and that the services were personally rendered by Provider or under Provider's personal supervision.

G. That every electronic claim entry submitted by Provider or Provider's billing agent is capable of being associated and identified with corresponding source documents. The source documents shall contain the same client authorizations and signatures as required for claims submitted on appropriate paper form.

H. That all source documents pertaining to each electronic claim submitted by Provider will be retained by Provider or Provider's agent for the records retention period specified in Provider's contract(s) to provide services for Texas Health and Human Services.

I. That Provider is solely responsible for the accuracy of all electronic claims submitted to Contractor by Provider or Provider's billing agent.

J. Provider will research and correct all billing discrepancies, and any incorrect payments discovered will be adjusted according to the applicable provisions then in effect for such claims.

* Indicates a required field.

K. Provider will unconditionally, upon request, provide free copies of and access to records pertaining to the services for which claims are submitted to LTC programs to representatives designated by the Texas Health and Human Services Commission, the United States Department of Health and Human Services (HHS), the Texas Attorney General's Medicaid Fraud Control Unit and/or the health insuring contract for Medicaid, with respect to the operation of the Texas Medical Assistance Program.

L. Except as provided in K above, that confidentiality of recourse and other information be maintained relating to clients in accordance with state and federal laws, rules, and regulations.

M. Provider shall assume all necessary personal responsibility and review of the internal procedures used to develop, transcribe, data enter, and transmit all required claim information for payment. Provider shall also assume personal responsibility for verification of charges submitted for payment. This administrative control and review shall consist of the following minimum participation requirements:

   1. The individual Provider's signature or an authorized Provider representative's signature (as appropriate for the type of service) on the source document verifies that services were performed as billed.

   2. Each source document must reflect the information specified in regulations or instructions applicable to the service for which a bill is submitted.

N. This Agreement shall become effective as of the date first herein above written, when executed by all parties and shall remain in effect until terminated by Provider or Contractor. Provider or Contractor may terminate this Agreement by giving thirty (30) days prior written notice of their intent to terminate. IN WITNESS WHEREOF, Contractor and Provider have caused this Agreement to be executed by their duly authorized representatives.

III. Provider acknowledges that the claims will be paid from federal and/or state funds, and that anyone who submits falsified claims, or who misrepresents or falsifies, or causes to be misrepresented or falsified, any record or other information relating to that claim or information that is required pursuant to this Agreement may, upon conviction, be subject to fine and/or imprisonment under applicable federal or state law.

IV. The Provider agrees to submit a "Request for Services" form and understands that only through this form or the "Request for Services Change" form will electronic submission privileges be assigned to a provider number (vendor/contract).

V. By signing this Agreement, the State, Contractor, and Provider accept all of the stipulations in this Agreement and agree to each and every provision therein.

Provider	Texas Medicaid & Healthcare Partnership
	For TMHP Use Only (Please Do Not Write In This Area) **Approved / Rejected**
Legal Name of Provider including DBA*	Submitter ID
Signature of Provider Representative*	Password
Name of Person Signing (please type or print)*	Signature
Title*	Date
Address*	*TMHP EDI Department*
City, State, ZIP*	

* Indicates a required field.

Electronic Data Interchange Agreement

On this ____________________________ Texas Medicaid & Healthcare Partnership, hereinafter called "Contractor,"
Date

and ____ , ______________________________ ,
*Legal Name of Provider including DBA** *Provider Number**

hereinafter called "Provider," enter into the following agreement. WHEREAS, Contractor processes claims for Long Term Care programs, hereinafter called "LTC" in the State of Texas; WHEREAS, Provider desires to submit claims for reimbursement under one or more of the LTC programs in a machine readable form via electronic media; NOWTHEREFORE, Contractor and Provider agree between and among each of them as follows:

I. Contractor agrees to accept from Provider (or from any billing agent Provider employs) electronic claims for reimbursement under the Texas Health and Human Services LTC programs and process such claims in the same manner as it would process claims submitted by Provider on the appropriate paper claim form, but only upon and subject to the terms and conditions of this Agreement.

II. Provider agrees:

A. That all electronic claims submitted by Provider or Provider's billing agent will:

1. Be in a format acceptable to Contractor for the program(s) involved.
2. Be submitted in accordance with Contractor's electronic claims billing procedures.
3. Contain all information required by Contractor.

B. That no claims that require individual consideration will be submitted through the electronic claims process, including, but not limited to, claims requiring supporting documentation.

C. That Provider has complied with the contractual and licensure requirements, laws and regulations of the various state and federal agencies, and conditions that would allow Provider to participate in and receive reimbursement under the LTC program(s) for which claim is made.

D. That electronic claims submitted to Contractor by Provider or by any billing agent Provider might choose to employ shall contain true, accurate, and complete information.

E. Provider will review for accuracy claims payment information from claims processed by Contractor. Provider may request an adjustment of a payment decision from the Contractor within the requisite number of days for the appropriate program under which the claim was filed.

F. The cashing of each warrant or receipt of direct deposit for claims paid to Provider will be a representation and certification that Provider presented the bill for the services shown on the accompanying explanation of payment forms and that the services were personally rendered by Provider or under Provider's personal supervision.

G. That every electronic claim entry submitted by Provider or Provider's billing agent is capable of being associated and identified with corresponding source documents. The source documents shall contain the same client authorizations and signatures as required for claims submitted on appropriate paper form.

H. That all source documents pertaining to each electronic claim submitted by Provider will be retained by Provider or Provider's agent for the records retention period specified in Provider's contract(s) to provide services for Texas Health and Human Services.

I. That Provider is solely responsible for the accuracy of all electronic claims submitted to Contractor by Provider or Provider's billing agent.

J. Provider will research and correct all billing discrepancies, and any incorrect payments discovered will be adjusted according to the applicable provisions then in effect for such claims.

K. Provider will unconditionally, upon request, provide free copies of and access to records pertaining to the services for which claims are submitted to LTC programs to representatives designated by the Texas Health and Human Services Commission, the United States Department of Health and Human Services (HHS), the Texas Attorney General's Medicaid Fraud Control Unit and/or the health insuring contract for Medicaid, with respect to the operation of the Texas Medical Assistance Program.

L. Except as provided in K above, that confidentiality of recourse and other information be maintained relating to clients in accordance with state and federal laws, rules, and regulations.

M. Provider shall assume all necessary personal responsibility and review of the internal procedures used to develop, transcribe, data enter, and transmit all required claim information for payment. Provider shall also assume personal responsibility for verification of charges submitted for payment. This administrative control and review shall consist of the following minimum participation requirements:

1. The individual Provider's signature or an authorized Provider representative's signature (as appropriate for the type of service) on the source document verifies that services were performed as billed.
2. Each source document must reflect the information specified in regulations or instructions applicable to the service for which a bill is submitted.

N. This Agreement shall become effective as of the date first herein above written, when executed by all parties and shall remain in effect until terminated by Provider or Contractor. Provider or Contractor may terminate this Agreement by giving thirty (30) days prior written notice of their intent to terminate. IN WITNESS WHEREOF, Contractor and Provider have caused this Agreement to be executed by their duly authorized representatives.

III. Provider acknowledges that the claims will be paid from federal and/or state funds, and that anyone who submits falsified claims, or who misrepresents or falsifies, or causes to be misrepresented or falsified, any record or other information relating to that claim or information that is required pursuant to this Agreement may, upon conviction, be subject to fine and/or imprisonment under applicable federal or state law.

IV. The Provider agrees to submit a "Request for Services" form and understands that only through this form or the "Request for Services Change" form will electronic submission privileges be assigned to a provider number (vendor/contract).

V. By signing this Agreement, the State, Contractor, and Provider accept all of the stipulations in this Agreement and agree to each and every provision therein.

Provider	Texas Medicaid & Healthcare Partnership
	For TMHP Use Only (Please Do Not Write In This Area) **Approved / Rejected**
Legal Name of Provider including DBA*	Submitter ID
Signature of Provider Representative*	Password
Name of Person Signing (please type or print)*	Signature
Title*	Date
Address*	*TMHP EDI Department*
City, State, ZIP*	

Request for Electronic Services

All sections of the Request for Electronic Services must be complete and accurate before the request can be processed. All of the information provided must match the provider's contract with the State of Texas with the exception of Section IV: Mailing Address. **Only one provider number per agreement is allowed.** Incomplete or inaccurate forms will be faxed back to the provider with a list of the necessary corrections. The provider will then be required to submit a full "clean" agreement.

Section I: Provider Address Information

Please setup the following provider for electronic services:

Legal name of provider including DBA*

Provider Number*

Legal name of provider including DBA (cont.)

Street Address

Telephone

City

State

ZIP Code

Section II: Submitter ID for EDI Transactions

A Submitter ID is necessary for all TMHP electronic services. The Submitter ID serves as an electronic mailbox for the provider and for TMHP to exchange data files. All providers will be set up to access the ANSI 835 report as part of this agreement. The ANSI 835 report can only be available to one Submitter ID. The ANSI 835 report will be set up on the same Submitter ID used to process the agreement, unless the provider checks the box labeled "I want the ANSI 835 report to go to a different Submitter ID than the one listed above." Please read the instructions carefully before completing this section. For any questions, please contact the EDI Helpdesk at 888-863-3638.

- Providers who choose to utilize TexMedConnect to retrieve ANSI 835 reports from TMHP can provide an existing Submitter ID or have a new Submitter ID generated by checking the box marked "Generate a new TexMedConnect Submitter ID."
- Providers who use any other software to submit and retrieve electronic files directly from TMHP can provide a Submitter ID or may order one by checking the box marked "Generate a new ANSI Submitter ID **for Software (Name)….**" TMHP will not issue a Submitter ID for software that has not completed the EDI testing process. Providers can view a complete list of software that has passed the testing process by clicking here: www.tmhp.com/sites/default/files/file-library/edi/5010 Approved Vendors.pdf. Or, call the EDI Helpdesk at 888-863-3638, before completing the form.
- Providers who submit and retrieve electronic files indirectly through a billing agent (i.e., clearinghouses, third party billing, or any other indirect method) must provide a Submitter ID. If providers do not know the billing agent's Submitter ID, they must contact that billing agent to obtain it. The EDI Helpdesk will never give out a billing agent's Submitter ID.

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- Providers who would like to retrieve their ANSI 835 report with a different Submitter ID than the one used to process the agreement should check the box labeled "I want the ANSI 835 report to go to a different Submitter ID than the one listed above."

I will use TexMedConnect Online services to retrieve the ANSI 835 report.

Generate a New TexMedConnect Submitter ID

OR

The existing Submitter ID is: ______________________________

I will use some other software.

Generate a New ANSI 835 Submitter ID for Software (Name): ______________________________

OR

The existing Submitter ID is: ______________________________

I will use a billing agent (i.e., a clearing house, a third party biller, or another indirect method).

The existing Submitter ID is: ______________________________

I want the ANSI 835 report to go to a different Submitter ID than the one listed above.

The existing Submitter ID is: ______________________________

Type of Access Required

Long Term Care

270/271 Eligibility Verification

276/277 CSI

835 Electronic Remittance and Status

837 Dental

837 Institutional

837 Professional

Section III: Provider Attestation

I (we) attest to the accuracy of the information provided on this request. I (we) authorize the exchange of data as defined in this request.

______________________________ ______________________________
Signature of Provider Representative* Name (please print)*

______________________________ ______________________________
Title* Date*

* Indicates a required field.

Section IV: Mailing Address

The fax number given here will be used to fax one copy of the signed agreement, as well as any deficiency letters, back to the provider. This information does not have to match the address given elsewhere on the agreement.

Provider Number*

Mailing Address*

Provider Name*

Telephone Number*

Attention

Fax Number*

Email Address*

Signature*

Date*

* Indicates a required field.