



**STATE OF ALASKA**  
**Department of Health and Social Services**  
**BILLING AGENT INFORMATION SUBMISSION AGREEMENT**

The following constitutes an Information Submission Agreement between a Billing Agent, Clearing House, or other entity (“Billing Agent”) and the State of Alaska, Department of Health and Social Services (“State”). The terms of this agreement govern the submission, by the Billing Agent, of the Provider’s clinical and financial information sent in support of services performed by the Provider.

I, \_\_\_\_\_, as Billing Agent, enter into this Billing Agent Information Submission Agreement with the State as authorization to submit, in either electronic or paper format, the Provider’s clinical and financial information directly to the State on behalf of the Provider. All information submitted under the terms of this agreement is in support of services performed by the Provider.

Section I. Terms of Agreement ( <i>To be completed by the “Billing Agent”</i> )
1. I am the Billing Agent named above.
2. I agree to comply with all state and federal laws as they apply to the State of Alaska, Department of Health and Social Services programs in which I participate.
3. I agree that payment and satisfaction of claims that I submit, including electronic transactions, 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 or state laws.
4. I agree to comply with the current and future Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) for all services, information, and transactions, including electronic transactions, privacy, and security regulations.
5. I agree that any transactions completed under this agreement will be compliant with all state and federal laws, including Title VII of the Civil Rights Act of 1964, which prohibits exclusion or discrimination on the basis of race, color, religion, sex, or national origin.
6. I agree to test any changes or modifications to my electronic file or file layout and seek approval of my test submission by the State. I understand that failure to do so may result in claim processing delays.
7. I agree to provide the State 30 days notice to set up or change electronic file or file layout specifications for information submissions. I agree to cooperate by transmitting test transactions to the State during a set-up period prior to any transmission to the State. I understand that the duration of testing may be 30 days or more.
8. I agree, as applicable, to submit Alaska-specific data elements in accordance with State of Alaska Medical Assistance Provider Billing Manuals, Companion Guides, and other State Program Guides to the extent that Alaska-specific data elements do not change the meaning or intent of any of the Health and Human Services (HHS) Transaction Standard’s implementation specifications (45 CFR Part 162.915(d)) and/or do not change any definition, data condition or use of a data element or segment as proscribed in the HHS Transaction Standard Regulation. (45 CFR Part 162.915(a)).
9. I agree that I have the responsibility to ensure that all information is complete and accurate, and that all electronic transactions meet the standards for HIPAA compliance.



19. By my signature below, I attest that
- (a) I have been authorized by properly enrolled Provider(s) in the State of Alaska, Department of Health and Social Services program, to submit information, including claims, on behalf of that (those) Provider(s) to the State; and
  - (b) I will only submit information, including claims, on behalf of the provider(s) from whom I have legal authorization to do so.
  - (c) I agree to notify the State, by the close of business on the next working day for the State of Alaska, if for any reason I revoke or terminate any agreement with the above Provider(s).
  - (d) I agree to notify the State of any change to my Billing Agent address, telephone, or other required information within three (3) working days.

20. I agree to comply with all items numbered 1-19 listed above. By my signature below, I acknowledge my responsibility for compliance with this agreement and my authority to enter into this agreement on behalf of the Billing Agent.

\_\_\_\_\_  
 Provider Business Name (print)      State Provider Identification Number      NPI(s)  
(List on Back if more space is needed)      (List on Back if more space is needed)      (List on Back if more space is needed)

\_\_\_\_\_  
 Billing Agent's Business Name

\_\_\_\_\_  
 Billing Agent's Mailing Address

\_\_\_\_\_  
 Billing Agent's Physical Address

\_\_\_\_\_  
 Billing Agent's Contact Name      Billing Agent's Contact Telephone Number

\_\_\_\_\_  
 Billing Agent's Main Telephone Number      Billing Agent's E-Mail Address

Section I. Terms of Agreement, continued *(To be completed by the "Billing Agent")* Signature Required. (No photocopies or facsimile signatures will be accepted.)

\_\_\_\_\_  
 Billing Agent's Fax Number

\_\_\_\_\_  
 Billing Agent's Authorized Representative\* Name and Title

\_\_\_\_\_  
 Signature of Billing Agent's Authorized Representative\*      Date

*\*An authorized representative is an appointed official to whom the Billing Agent has granted the legal authority to submit information to the Medicaid program, to make changes and/or updates to the Billing Agent's status in the Medicaid program (e.g., changes of address, etc.), and to commit the Billing Agent to fully abide by the laws, regulations, and program instructions of the Medicaid program. The authorized official must be a general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the Billing Agent company, or must hold a position of similar status and authority within the Billing Agent's organization.*

Section II. Definitions

“Billing Agent” used in this agreement means: Any Billing Agent, Clearinghouse, billing service, other third party submitter, contractors, or other entity submitting information directly to the Alaska Medical Assistance Program, State of Alaska, Department of Health and Social Services on behalf of an enrolled Provider.

“Provider” used in this agreement means: A party who is properly enrolled in the State of Alaska Department of Health and Social Services program(s) including as applicable, the Alaska Medical Assistance Program, and authorized to provide and be reimbursed for covered services.

“State” used in this agreement means: The State of Alaska, Department of Health and Social Services or its designee.

Section III. To Be Completed by the State or its Designee

The State agrees to continue to mail checks, remittance advices, resubmission turnaround documents etc., directly to the Provider, Provider’s Billing Agent, or other entity as recorded on the State’s Medicaid Management Information System (MMIS) provider and submitter files. The State agrees to comply with all HIPAA laws.

This agreement is effective and begins on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_. The above Billing Agent is authorized to submit information, which may include claims, to the State on behalf of the above listed Provider(s).

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

State Representative or designee Name, Title, and (if applicable designee’s Company or Agency Name)

\_\_\_\_\_  
State or State’s designee Signature

\_\_\_\_\_  
Date of Signature

Section IV. To Be Completed by the State or its Designee

	Begin date	End date
<b>Test</b> Submitter # assigned to this Billing Agent _____	_____	_____
<b>Production</b> Submitter # assigned to this Billing Agent _____	_____	_____

Termination effective date: \_\_\_\_\_ Date termination notification received: \_\_\_\_\_

Hard copy file updated \_\_\_\_\_

MMIS file updated: \_\_\_\_\_

Electronic submitter file updated: \_\_\_\_\_