



STATE OF ALASKA
Department of Health and Social Services
INSTRUCTIONS TO BILLING AGENT FOR COMPLETING
THE BILLING AGENT INFORMATION SUBMISSION AGREEMENT

1. In the blank at the top of the form, fill in the Billing Agent business name:

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.

2. ***Section I – Terms of Agreement***

Section I, items #1 through #13 – These items are statements that a Billing Agent agrees to when the Information Submission Agreement is signed. Please read all items carefully.

Section I, item #14 – Check the appropriate box. Please indicate if the information you submit will be HIPAA compliant or not.

Section I, item #15 – (a) – Check the appropriate box. Indicate whether *claims* information submitted to Alaska Medical Assistance will be in paper or electronic format.

(b) – Check the appropriate box. Indicate whether other information (see list in #17) submitted to Alaska Medical Assistance will be in paper or electronic format.

Section I, item #16 – Check the appropriate box.

a. If you will be sending your information directly from your office software to Alaska Medical Assistance, check the first box (*Billing Agent office system*).

b. If you are submitting information for a pharmacy provider and will use the Point of Sale (POS) system, check the 3rd box (*Point of Sale*).

Section I, item #17 – Check all boxes that apply or will apply within the next year. *If you do not plan to submit HIPAA-compliant transactions, check the last box, “N/A (Not Applicable).”*

Section I, item #18 – Complete this field only if you checked box 16a. If you will be using HIPAA-compliant software, fill in the requested information about your software vendor. If there are any technical problems with information submission, we may use the information you provide to contact the vendor.

Section I, item #19 – By signing the Billing Agent Information Submission Agreement, you agree to abide by items 19a – 19d.

Section I, item #20 – **This item must be completed for the Information Submission Agreement to be valid.**

The “Provider Business Name” field should contain the provider’s pay-to business legal name. This name must match the business name provided to the IRS when the business applied for a Tax ID #.

The “State Provider Identification Number(s)” field should contain all Alaska Medicaid identification numbers for the provider named above.

Complete the name, mailing and physical address information about the Billing Agent (you).

Provide Billing Agent contact information for someone who can discuss your Information Submission Agreement or submitted information with Affiliated Computer Services, Inc. or the State of Alaska.

The “Billing Agent’s Authorized Representative Name and Title,” and “Signature of Billing Agent’s Authorized Representative” fields should contain an individual’s name and title. An authorized representative 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’s company, or must hold a position of similar status and authority within the Billing Agent’s organization.

3. Sections III, IV – Do not complete. These sections are reserved for the State of Alaska and Affiliated Computer Services.