



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

1. In the blank at the top of the form, fill in the provider's business name:

I, \_\_\_\_\_, as Provider, enter into this Provider Information Submission Agreement with the State as authorization to submit clinical and financial information directly to the State either: (1) electronically by me; or (2) in an electronic or paper format through a Billing Agent on my behalf. All information submitted under the terms of this agreement is in support of service performed by me.

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

Section I, items #1 through #15 – These items are statements that a provider agrees to when the Information Submission Agreement is signed. Please read all items carefully.

Section I, item #16 – Check the appropriate box. Regardless of whether you will be submitting information directly from your office, or authorizing submission by another entity, please indicate if the information will be HIPAA compliant or not.

Section I, item #17

a. Check the appropriate box. Indicate whether *claims* information submitted to Alaska Medical Assistance will be in paper or electronic format. If you are using a separate entity (billing agent, clearinghouse, etc.) to submit claims transactions, check the box indicating the format that the separate entity will be using.

b. Check the appropriate box. Indicate whether other information (see list in #18) submitted to Alaska Medical Assistance will be in paper or electronic format.

Section I, item #18 – 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 #19 – Check the appropriate box.

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

b. If you will be using *Payerpath<sup>SM</sup>* directly, or if you will be using a separate entity to submit information that will ultimately reach Alaska Medical Assistance through *Payerpath<sup>SM</sup>*, check the 2<sup>nd</sup> box (*Payerpath<sup>SM</sup>*).

c. If you are a pharmacy provider and use the Point of Sale (POS) system, check the 3<sup>rd</sup> box (*Point of Sale*).

d. If you will be using a billing agent, clearinghouse, contractor, or other third-party entities, check the 4<sup>th</sup> box (*Billing Agent or Clearinghouse*).

Section I, item #20 – 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 #21 – This section is your authorization for another party to submit information on your behalf. You only need to complete this section if you will be using a Billing Agent/Clearinghouse/contractor or other entity to submit your information. You only need to provide information about the entity submitting *directly* to Alaska Medical Assistance. You do not need to provide any information about other companies that may handle your information between you and the final Billing Agent/Clearinghouse/contractor.

Section I, item #22 – This item asks for contact information. Please provide the requested information for someone who can discuss your Information Submission Agreement or submitted information with Affiliated Computer Services, Inc. (ACS) or the State of Alaska. If you do not want ACS or the State of Alaska communicating with anyone but yourself, check the box provided.

Section I, item #23 – **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 (only one ID per Agreement)” field should contain one State Provider Identification Number only. If you are a provider who practices individually *and* as a member of a group, you should fill out an agreement for your individual practice. A group practice authorized representative will fill out a separate agreement for the group.

The “Provider’s Name or Authorized Representative’s Name,” “Signature of Provider or Authorized Representative,” and “Title as applicable (print)” fields should contain an individual’s name and title. If the provider’s business is a sole proprietorship or owned by an individual, the individual owner/proprietor must sign and date the agreement. If an authorized representative is signing and dating the agreement, that 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 provider’s organization, or must hold a position of similar status and authority within the provider’s organization.

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