

PROVIDER REQUEST FOR ASSOCIATION WITH A BILLING AGENT

TO ADD A BILLING AGENT

___ I hereby authorize the Department of Developmental Disabilities [DODD] to accept claims from the billing agent named below beginning on the effective date noted. This authorization allows the billing agent to submit claims on my behalf; access claims files and related information such as provider weekly reports, as well as request billing histories and other documentation to assist with maintaining accurate records. I understand that:

___ I remain completely and solely responsible for all claims submitted on my behalf;

___ It is my responsibility to request access to and view provider weekly reports, available through the Medicaid Billing System, to ensure that claims submitted on my behalf are in accordance with what services I actually delivered;

___ The billing agent named below is acting on my behalf and under my employment, and DODD does not employ, monitor, or guarantee the performance of any billing agent, nor shall DODD be responsible or liable directly or indirectly for any loss or dispute related to the use of a billing agent.

___ It is my responsibility for meeting all HIPPA [Health Insurance Portability and Accountability Act] requirements, including having a signed Business Associate Agreement with my billing agent that explains my billing agent's obligations for confidentiality. [An example of this agreement can be found on the U.S. Department of Health and Human Services website.]

___ This association with the below billing agent will remain in effect until I notify DODD in writing that I wish it to be rescinded.

[Initial all 6 lines]

01/17/2014

TO RESCIND A BILLING AGENT

___ I hereby request the association to the billing agent named below to be rescinded effective on the date noted.

Provider Name:	Provider Contract #:
Provider Email address:	Provider Phone #:
Provider Signature:	Today's Date:
Billing Agent Name:	Billing Agent Number:
Effective Beginning:	Effective Ending: [to rescind authorization]

Fill out and fax to: 614.752.4673, or scan and email to security.support@list.dodd.ohio.gov

This form supersedes all previous billing agent forms.

--DODD Use Only--

Provider Security Affidavit verified:	Association Made:
Billing Agent Affidavit verified:	Association Rescinded:

01/17/2014

Office of Information Technology Services/ Security and Operations
30 East Broad Street 12th Floor Columbus, Ohio 43215-3414
E-mail: security.support@list.dodd.ohio.gov Fax: 614.752-4673
The State of Ohio is an Equal Opportunity Employer and Provider of Services