

HOSPITAL, NURSING HOME/LTC, HCFA 1500, AND PHARMACY ELECTRONIC MEDIA PROVIDER AGREEMENT

Pursuant to Administrative Rule of South Dakota (67:16:35:05) this agreement is made and entered into by and between the Department of Social Services, State of South Dakota, also referred to as the "South Dakota Medical Assistance Program" and _____, also referred to as the "Provider". The purpose of this agreement is to enable the Provider to submit claims to the South Dakota Medical Assistance Program Agency with the use of electronic media.

It is hereby agreed as follows:

A. GENERAL PROVISIONS

1. This agreement will be automatically renewed for one year on July 1 if neither party gives notice requesting termination, except that the duration of this agreement may be limited pursuant to action by the South Dakota Medical Assistance Program in excluding a provider for fraud or abuse pursuant to 42 CFR Part 1002. This agreement may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party.
2. This agreement may be modified in writing by mutual consent of the South Dakota Medical Assistance Program and the Provider. Any such modification shall be attached to this agreement and become a part thereof.
3. The Provider must be an authorized medical assistance provider with a signed Standard Provider Agreement on file in order to enter into this agreement.
4. This agreement will in no way supersede the Standard Provider Agreement.

B. RESPONSIBILITIES OF THE PROVIDER/BILLING AGENT

1. Claims submitted by electronic media must comply with the format specifications defined by the South Dakota Medical Assistance Program. Failure to comply with the format specifications will result in the electronic claim being rejected.
2. The provider will notify the South Dakota Medical Assistance Program if the provider changes software providers or billing agents.

C. RESPONSIBILITIES OF THE SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM

If the above mentioned requirements are met the South Dakota Medical Assistance Program shall be responsible for the following:

1. The South Dakota Medical Assistance Program will process and reimburse the Provider in a timely manner for all covered services submitted via electronic media.
2. The South Dakota Medical Assistance Program will notify the Provider/Billing Agent of any changes that may occur in the format specifications.

PROVIDER

Provider Type: _____HCFA _____Hospital _____Pharmacy _____Nursing Home/LTC

How are you submitting? _____POS _____Launch Pad/Web Application

Provider Name (Typed)

Provider Number

National Provider Identification (NPI) Number: _____

Authorized Signature

Tax ID Number

Contact Person (Typed)

E-Mail Address

Telephone Number

Title (Typed)

Date



BILLING AGENCY

Billing Agency

Billing Agency Submitter Number

Street Address

City, State and Zip Code

Contact Person (Typed)

Telephone Number

E-Mail Address

835 Electronic Remit _____YES _____NO **277 Claim Status Response** _____YES _____NO



TO BE COMPLETED BY SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM

Start Date _____

Approved By: _____
Larry Iversen, Division Director

Date: _____