

Billing agents

You may choose to contract with a billing agent rather than to submit your own claims. As a provider, you are responsible for the accuracy and completeness of all claims, including those submitted by a billing agent. You are also responsible for safeguarding individually identifiable health information as defined by the Health Insurance Portability and Accountability Act [HIPAA] of 1996. This would include information such as your client's name, Medicaid number, and Social Security Number, that your billing agent may have access to as your agent of employ. You are required to have a signed Business Associate Agreement that explains your 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.

<http://www.hhs.gov/SampleBusinessAssociateContract>

Billing agents are employed by providers, and are not employees of the Ohio Department of Developmental Disabilities, the Ohio Department of Medicaid, or any other state or local agency, and DODD does not monitor or guarantee the performance of any billing agent, nor do we recommend or endorse billing agents. DODD shall not be responsible or liable directly or indirectly for any loss or dispute related to the use of a billing agent.

To become associated with a billing agent, you will need to fill out a Provider request for association with a billing agent, available on the next page. This outlines the responsibility of the provider and of the billing agent. You will use the same form to become disassociated with a billing agent.

If you wish to become a billing agent, you will need to fill out a [security affidavit](#). The account type is 'Independent or Agency Provider', the request type is 'New Account', and the provider type is 'Billing Agency'. You can use 9999999 as the contract number where indicated. Indicate on the form that you are requesting a billing agent number. Print out and sign the affidavit.

You can Fax the affidavit to:

Attn: Security Coordinator
Fax# (614) 752 - 4673

or you can mail the affidavit to:

Attn: Security Coordinator
Division of Information Systems
30 E Broad St. 12th Floor
Columbus, OH 43215

After you receive your billing agent number from Security, you will need to contact dodd.support@dodd.ohio.gov if you wish to be added to our list of billing agents. Please include your name or agency name, address, contact person, phone number and email address.

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]

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: