

Texas CHIP Dental Services
Electronic Data Interchange (EDI)
Enrollment Packet

This enrollment packet consists of the following:

1. **Delta Dental State Government Programs Telecommunications Provider and Biller Application/ Agreement**
2. **Provider Service Office Electronic Data Interchange Option Selection Form**
3. **EDI Supply Request Form**

An EDI How-To Guide, which provides detailed information on electronic claims submission for Texas CHIP Dental Services, should accompany this packet.

To submit your Texas CHIP claims electronically:

1. **Check with your vendor.**
Contact your practice management system vendor for verification that your software includes Delta Dental State Government Program's (DDSGP) EDI specification.
2. **Complete the attached Provider and Biller Application/Agreement and Option Selection Form.**

Mail the application (all four pages) and Optional Selection Form to the following address. Include separate Option Selection Forms for additional service offices. Delta will confirm your enrollment by letter.

Delta Dental State Government Programs
Texas CHIP Dental Services
EDI Support Group
P.O. Box 537018
Sacramento, CA 95853-7018

IMPORTANT: YOUR CLAIMS WILL BE REJECTED IF YOU ARE NOT ENROLLED AS AN EDI PROVIDER PRIOR TO SUBMITTING TX CHIP CLAIMS ELECTRONICALLY.

3. **Order your EDI supplies.**
If x-rays or attachments are needed to process your claim or Treatment Authorization Request (TAR), you will need to submit an EDI label attached to a specially marked envelope. Use the attached EDI Supply Request Form to order a supply of all three types of envelopes (large and small x-ray envelopes, and large mailing envelopes) and self-adhesive EDI labels. These supplies are provided at no charge and are printed in teal ink to identify them as related to EDI claims.
4. **Enter and transmit claims to Delta Dental Texas CHIP Dental Services.**
Your practice management system vendor will advise you how to use your computer and modem to submit your Texas CHIP claims electronically.
5. **Retrieve your reports and labels each workday.**
Follow your software vendor's instructions. Depending on how your system is linked to DDSGP, you may receive your reports and labels through a clearinghouse. Check for reports each workday. Even if you did not submit any EDI claims the prior workday, you may have NOAs & RTDs waiting to be retrieved, if your system is set up to receive them electronically.

Note: Check with Provider Services regarding claim status and payment of services.

If you have any questions, please call our Provider Call Center at (866) 561-5891.
Call Center hours are Monday - Friday 8:00 a.m. 7:00 p.m. (CST).

**TELECOMMUNICATIONS
PROVIDER AND BILLER APPLICATION / AGREEMENT
(For electronic claim submission)**

1.0 IDENTIFICATION OF PARTIES

This agreement is between **Delta Dental Insurance Company, ("DDIC")** (hereinafter referred to as "DDIC") and the person(s) listed below:

PROVIDER INFORMATION			
Provider name (full legal)		Provider Billing Number	
DBA (if applicable)		National Provider Identifier (NPI)	
Provider's address (number, street)	City	State	ZIP Code
Contact person			
Contact person's address, if different (number, street)	City	State	ZIP Code
Contact telephone number	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		
BILLER INFORMATION (If other than the provider of service)			
Biller name (full legal)		Biller telephone number	
DBA (if applicable)			
Business Address (number, street)	City	State	Zip
Contact Person	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number)		
<i>Full legal name(s) required as well as any assumed (DBA) names(s), address(es), and SGP's provider number. The parties identified above will be hereinafter referred to as the "Provider" and/or "Biller."</i>			

1.1 EDI DATA TYPES

(Refer to Provider Service Office Electronic Data Interchange Option Selection Form):

- ANSI X 12 837 (Claims/TARs/RTDs/NOAs/Adjustments)
- ANSI X 12 276/277 (Claim Status Inquiry/Responses)
- ANSI X 12 835 (Claim Payment/Remittance Advise)-when available
- ANSI X 12 270/271 (Eligibility-Benefit Inquiry/Response)

1.2 BACKGROUND INFORMATION

Provider/Biller agrees to complete this application and provide the above requested information which Delta Dental State Government Programs (DDSGP) will rely upon to pay bills electronically to Provider. Provider/Biller agrees to notify DDSGP immediately if any of the above information changes.

2.0 DEFINITIONS

When used in this agreement, the following terms will have the following meaning:

"CHIP Dental Plan" means the Texas Children's Health Insurance Program dental plan.

"Delta Dental" means Delta Dental State Government Programs (DDSGP), third party administrator (TPA) responsible for paying claims for Delta Dental Insurance Company, the CHIP Dental Plan underwriter.

“Electronic” and “electronically,” when used to describe a means of submitting a claim shall include all means or mode of electronic transmission, such as: magnetic tape or modem communications.

“Provider Manual” means the booklet describing Delta Dental’s policies, procedures and guidelines by which Provider is required to provide dental services to CHIP Dental Plan enrollees and which is incorporated by reference into the Provider Contract. Provider acknowledges that he has received, read and understands the Provider Manual and its contents and agrees to read and comply with all Provider Manual updates and bulletins received relating to electronic billing.

“Provider’s Contract” means the Texas CHIP Contracting Dentist Agreement between Provider and Delta Dental Insurance Company which authorizes Provider to provide covered services to a CHIP enrollee.

“Public Officials” mean those federal and Texas state governmental officials and their representatives and designees charged with the duty to discharge the provisions of state or federal law or regulation governing Provider/Biller and/or Delta Dental, or the CHIP Dental Plan.

3.0 CLAIMS ACCEPTANCE AND PROCESSING

DDSGP agrees to accept claims from Provider/Biller that are electronically submitted either directly or through a DDSGP clearinghouse in accordance with the procedures described in the brochure attached hereto as Exhibit A. Provider/Biller agrees to read and comply with these procedures and all updates when received. Provider/Biller shall use Provider’s assigned DDSGP Submitter ID and password when submitting an electronic claim. Provider/Biller shall maintain privacy of the password and shall be fully responsible for its use or misuse in the event that privacy is not maintained.

3.1 CLAIMS CERTIFICATION

Provider agrees to submit with each electronically submitted claim, a certification, under penalty of perjury, stating that: (i) the services have been provided to the patient either personally by Provider or under Provider’s direction by another DDSGP eligible person designated on the claim form; (ii) the services were, to the best of the Provider’s knowledge, medically indicated and necessary to the health of the patient; and (iii) all information submitted with the claim is accurate and complete.

3.2 RECORDS RETENTION

Provider/Biller agrees to maintain for a period of at least six (6) years following the date of service an electronic archive of all records necessary to fully disclose the extent of services furnished to the patient. A copy of such records shall be produced upon request by either DDSGP or Public Officials in accordance with the provisions of Provider’s Contract.

3.3 VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

Notwithstanding Provider’s engagement and use of Biller, Provider shall be personally responsible for all claim information transmitted electronically for payment by Biller on Provider’s behalf.

3.4 ACCURACY AND CORRECTION OF CLAIMS OR PAYMENTS

Provider shall be responsible for reviewing and verifying the accuracy of claims’ payment information promptly upon the receipt of payment. Provider agrees to seek correction of claim errors in accordance with the procedures outlined in the Provider Manual. Provider/Biller acknowledges that anyone who misrepresents or falsifies or causes to be misrepresented (or falsified) any records or other information relating to a claim may be subjected to legal action, including, but not limited to: criminal prosecution, action for civil monetary penalties, action for restitution of funds paid, termination of this agreement and/or termination of Provider’s Contract.

4.0 CHANGES IN ELECTRONIC BILLING STATUS

Provider/Biller and DDSGP each agree to notify the other of any changes that might affect Provider/Biller status or eligibility to participate in electronic billing.

5.0 PROVIDER/BILLER REVIEWS

Provider/Biller agrees to cooperate with all audits and reviews conducted by DDSGP and/or Public Officials to ensure compliance with applicable federal and/or state law and with this agreement. Provider/Biller agrees to make available all source documents necessary to verify the accuracy and completeness of electronically submitted claims.

5.1 NONEXCLUSIVE REVIEWS

Provider/Biller agrees that the provisions of paragraph 5.0 are in addition to any other obligations imposed upon Provider/Biller by the Provider's Contract or applicable federal and/or state law.

6.0 EFFECTIVE DATE

This agreement shall become effective upon acceptance and approval of Provider's/Biller's Application by DDSGP.

6.1 TERMINATION

DDSGP or Provider/Biller may terminate this agreement with or without cause by giving 30 days prior written notice of the intent to terminate. Provider/Biller shall have no right to appeal any termination by DDSGP. Notwithstanding the foregoing, DDSGP may terminate this agreement immediately and without any advance notice upon determination pursuant to paragraph 6.2 that Provider/Biller has failed or refused to produce or retain source documents in accordance with applicable federal and/or state law or this agreement.

6.2 FAILURE TO PRODUCE OR RETAIN SOURCE DOCUMENTS

If Provider/Biller is unable, fails or refuses to produce source documents on request made pursuant to paragraph 5.0, of this agreement, DDSGP may terminate this agreement immediately and without advance notice. Upon such termination, DDSGP shall cease payment of any and all electronic claims submitted by Provider/Biller, including claims in process on the date of such termination. Provider/Biller shall have no right to appeal DDSGP's termination pursuant to this paragraph prior to the effective date of such termination. Provider/Biller may file a grievance and shall have the right to appeal any adverse determination of said grievance pursuant to appeal procedures set forth in the Provider Manual. DDSGP shall have the right to demand repayment of money paid on claims for which no source documents are or have been produced and Provider/Biller shall have the right to file a grievance respecting such overpayment and appeal any adverse determination of said grievance pursuant to the Provider Manual.

6.3 EFFECT OF TERMINATION AND APPEAL

Termination of this agreement pursuant to either paragraph 6.1 or 6.2 above shall terminate Provider's/Biller's right to submit claims electronically and Provider/Biller shall thereafter be required to submit hard copy claims.

7.0 AGREEMENT BETWEEN PROVIDER AND BILLER (IF OTHER THAN THE PROVIDER OF SERVICE)

Provider agrees that the agreement between Provider and Biller(s) to submit electronic billings to DDSGP shall conform to federal and state law governing electronic claims submissions, and shall contain at a minimum, but not in limitation thereof, the following provisions:

- a. Provider shall specifically designate Biller as its agent for the purpose of preparing and submitting claims to DDSGP. As Provider's agent, Biller agrees to comply with all DDSGP requirements regarding record-making and retention as well as applicable federal and state laws and regulations regarding same.
- b. Electronic billing for services rendered to DDSGP beneficiaries shall be prepared by Biller solely from information supplied by Provider and shall include the Provider's usual and customary charges for the services rendered. A printed representation of source documents shall be maintained by Biller, including all information transmitted as a claim by Provider to Biller for a period of at least six (6) years from the date of the claim's submission in accordance with the provisions of the Provider's Contract and Provider Manual.
- c. Notwithstanding the provisions of 'b' above, in the event an audit by Public Officials, Biller shall be required to retain all original records until the completion and resolution of any audit of such records, even if the retention period extends beyond six years from the date of service.
- d. The parties agree that DDSGP may accept electronic billings prepared, certified, and submitted by the Biller on behalf of Provider only so long as the agreement between the Provider and Biller remains in effect.
- e. Provider/Biller agrees to notify DDSGP in writing immediately upon any change in or termination of their agreement.

8.0 PROVIDER TO HOLD STATE GOVERNMENT PROGRAMS HARMLESS

Provider represents that Provider is not relying upon any evaluation made by DDSGP of the electronic billing system, software, or Biller that Provider is using or intends to use for electronic billing. Provider assumes any and all risks that accompany electronic billing and agrees to indemnify and hold harmless DDSGP, and its officers, directors, agents and employees for any and all damages, costs and expenses caused or due to any failure of the billing software or other features of the electronic billing services to in the same manner as (hard copy) paper billing. Furthermore, Provider acknowledges that if the electronic billing system, software, or Biller selected by the Provider, is or has been listed as available in DDSGP bulletins, that such listing was not an endorsement by DDSGP, nor does it imply that the service, system, or software has met or is continuing to meet a standard of performance.

9.0 CONFIDENTIALITY OF RECORD

Provider/Biller agrees to provide adequate security precautions to protect the confidentiality of DDSGP records and claims submission methods in accordance with applicable federal and/or state law.

PROVIDER SIGNATURE INFORMATION		
Full printed name	Title	
Provider signature (original signature required; <i>DO NOT</i> use black ink)		Date
BILLING SERVICE SIGNATURE INFORMATION (complete only if "Billing Information" is completed on page 1 of 4)		
Full printed name	Title	
Owner or Corporate Office signature (original signature required; DO NOT use black ink)		Date

Return Application/Agreement to: Delta Dental
 State Government Programs
 EDI Support Group
 P.O. Box 537018
 Sacramento, CA 95853-7018



**PROVIDER SERVICE OFFICE
ELECTRONIC DATA INTERCHANGE
OPTION SELECTION FORM**

Delta Dental State Government Programs
Texas CHIP Dental Services
P.O. Box 537018
Sacramento, CA 95853-7018

PLEASE CHECK ONE OF THE FOLLOWING:

Begin Registration Terminate Registration Change Options

Provider Name (DBA):

Provider Billing Number:

Service Office:

NPI:

Address:

City:

State:

Zip:

Contact Name:

Phone Number:

E-mail Address:

Fax Number:

Software/Practice Management System:

EDI INPUT/OUTPUT OPTIONS

Identify the INPUT FROM and RETURN OUTPUT OPTIONS for your office in the fields below.
For assistance, contact EDI Support at (916) 861-2375.

INPUT FROM:

- Service Office (SO)
 Billing Office (BO)
 Clearing House (CH)

Name: _____

You will submit Claims, TARs and Adjustments (ANSI X 12 837).

Will you also submit:

- RTDs electronically? YES NO
NOAs electronically? YES NO
CIF Adjustments? YES NO
Claim Status Inquiry (ANSI X 12 276)? YES NO
Eligibility Inquiry (ANSI X 12 20)? YES NO

RETURN OUTPUT OPTIONS (standard options are shaded):

EDI Document	Requested?		Send to (Mark One)		
Electronic RTDs	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> SO	<input type="checkbox"/> BO	<input type="checkbox"/> CH
Electronic NOAs	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> SO	<input type="checkbox"/> BO	<input type="checkbox"/> CH
Electronic EOB Supplemental Claim Data	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> SO	<input type="checkbox"/> BO	<input type="checkbox"/> CH
Electronic X-Ray/Attachment Labels	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> SO	<input type="checkbox"/> BO	<input type="checkbox"/> CH
Report of Documents Awaiting Return Information (CP-0-978-P)	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> SO	<input type="checkbox"/> BO	<input type="checkbox"/> CH
Report of EDI Documents Received (CP-0-973-P)	<input checked="" type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> SO	<input type="checkbox"/> BO	<input type="checkbox"/> CH
Eligibility-Benefit Inquiry/Response (ANSI X 12 271) when available ..	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> SO	<input type="checkbox"/> BO	<input type="checkbox"/> CH
Claim Status Inquiry Response (ANSI X 12 277)	<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> SO	<input type="checkbox"/> BO	<input type="checkbox"/> CH

Authorized Applicant's Original Signature

Date

FOR DDSGP USE ONLY	
C/H ID:	
Remote ID:	
P/W:	
CV:	

Return completed form to:

Delta Dental
State Government Programs
EDI Support Group
P.O. Box 537018
Sacramento, CA 95853-7018

EDI SUPPLY REQUEST FORM

This form is to be used **only** to reorder Electronic Data Interchange (EDI) supplies for Delta Dental Texas CHIP Dental Services.

Billing Provider Name:	Provider Billing Number:
DBA (if applicable):	National Provider Identifier (NPI):
Mailing Address:	Telephone Number: ()
City, State:	ZIP Code:
Contact Name:	Contact Telephone Number: ()

EDI X-RAY ENVELOPES

Item	Description	Quantity
TX-54	Small X-ray Envelopes (for enclosing x-rays)	<input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30
TX-55	Large X-ray Envelopes (for enclosing x-rays)	<input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30
TX-56	Large Mailing Envelopes (to mail multiple x-ray envelopes)	<input type="checkbox"/> 10 <input type="checkbox"/> 20 <input type="checkbox"/> 30

EDI LABELS

Item	Description	Quantity
TX - 018A	3-up Laser Labels (12 labels per sheet)	<input type="checkbox"/> 5 <input type="checkbox"/> 10 <input type="checkbox"/> 20

If you have any questions or need help completing this form, please call our Provider Call Center at (866) 561-5891.

After completion of information, please mail or fax your request to:

Delta Dental State Government Programs
EDI Support Group
P.O. Box 537018
Sacramento, CA 95853-7018

FAX: (916) 852-8995
Attn: EDI Support Group