



# **State of New Mexico Medicaid Program**

## ***Electronic Data Interchange (EDI) Provider Enrollment Application***

**Do not use this form for submitting X835 Electronic Remittance Advice Enrollment requests. Please use the EDI Authorization form if you would like to Enroll with a Billing Agent or Clearinghouse to receive X835 transactions.**

# Name and Business Organization Information

All applicants must complete

## Direct EDI Transmission / Retrieval

**1. Name and Type of Business Practice**

**Provider Number** \_\_\_\_\_ **NPI Number** \_\_\_\_\_

**Tax ID** \_\_\_\_\_ **or Social Security Number** \_\_\_\_\_

**Individual Name:**

_____	_____	_____	_____
Individual's Last Name	First Name	M.I	Title/Degree

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**Business ventures (sole proprietors, groups, partnerships, and corporations)  
(Applying under a Tax ID)**

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Legal business name (exactly as registered with the Internal Revenue Service)

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Doing Business As (DBA) name (if applicable)

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**Institutions (Hospitals)**

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Legal business name (exactly as registered with the Internal Revenue Service)

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Doing Business As (DBA) name (if applicable)

This space for fiscal agent use

## Provider Address and Contact Information

All applicants must complete

### 2. Mailing Address and Telephone Number

Mailing Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

County: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

### 3. Contact Information

#### Primacy Contact Information/Trading Partner Administrator:

Contact Individual Name: \_\_\_\_\_

Contact Title: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Business Email Address: \_\_\_\_\_

## Secondary Contact Information/Trading Partner Administrator:

Contact Individual Name: \_\_\_\_\_

Contact Title: \_\_\_\_\_

Business Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Business Email Address: \_\_\_\_\_

## Provider/Submitter Electronic Information

All applicants must complete

In order to electronically submit claims, or electronically retrieve reports, applicants must complete these sections.

### 4. Please Indicate How You Plan to Submit Your Electronic Transactions

#### Electronic Transactions

Direct transmission /or retrieval (Direct Connect)

#### Transactions available for transmission (at least one must be checked)

- X12N 270 (Eligibility Inquiry)
- X12N 276 (Claim Status Inquiry)
- X12N 837P (Professional Claim)
- X12N 837D (Dental Claim)
- X12N 837I (Institutional Claim)

### 5. Transactions available for retrieval

#### Please select the transaction

- X12N 277CA (Payer Specific Reject Report)
- X12N 999 (Acknowledgement of Above Transactions)
- X12N 835 (Claim Payment Advice)
- X12N 271 (Eligibility Benefit Response)

## Provider Participation Agreement

All applicants must complete

**Note: Individual billing providers who plan on sending electronic transaction or receiving reports under a submitter ID must complete and sign the EDI provider enrollment form.**

# PROVIDER PARTICIPATION AGREEMENT

This Provider Participation Agreement (“Agreement”) is entered into by and between the New Mexico Human Services Department (“HSD”), its fiscal agent, Conduent State Healthcare, LLC (“Conduent”), and

\_\_\_\_\_,  
(Provider Name)

\_\_\_\_\_,  
(NPI Number)

(“Provider”), collectively “the Parties.” This Agreement is entered into in order to define HSD expectations of providers who perform services and submit billing, transactions, and/or data to the State of New Mexico Medicaid Program through its Fiscal Agent, Conduent. This Agreement is also established to facilitate business transactions by electronically transmitting and receiving data in agreed formats; to ensure the integrity, security, and confidentiality of the aforesaid data; and to permit appropriate disclosure and use of such data as permitted by law. This Agreement is to be considered in conjunction with the Provider Enrollment Form, if necessarily completed.

## RECITALS

A. The New Mexico Human Services Department (HSD) is the single state agency responsible for the administration of the State of New Mexico’s Medicaid Program pursuant to Title XIX of the Social Security Act.

B. Conduent has developed, on behalf of the New Mexico Human Services Department (HSD), a paperless transaction system that will process State of New Mexico’s Medicaid Program electronic transactions submitted through the designated electronic media.

C. Conduent is the contracted Fiscal Agent for the New Mexico Human Services Department (HSD), which is responsible for administration of the State of New Mexico's Medicaid Program. Although Conduent operates the computer system translator through which electronic transactions flow, HSD retains ownership of the data itself. Providers access the pipeline network through various means, over which the transmission of electronic data occurs. Accordingly, providers are required to transport data to and from Conduent.

D. Electronic transmission of any/all data shall be in strict accordance with the standards set forth in this Agreement and as defined by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated there under by the U.S. Department of Health and Human Services and other applicable laws, as amended.

E. This Agreement is subject to modification, revision, or termination according to changes in federal or state laws, rules, or regulations. This Agreement will be deemed modified, revised, or terminated to comply with any change on the effective date of such change.

F. This Agreement delineates the responsibilities of the Parties, and any agent, subcontractor, or employee of a Party, in regard to the State of New Mexico's Medicaid Program. As consideration for acceptance as an enrolled provider in the State of New Mexico's Medicaid Program, the Provider certifies and agrees to the terms and conditions set forth below.

## **Provider Participation Agreement - Continued**

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**All applicants must complete**

### **DEFINITIONS**

For the purpose of this Agreement:

A. "New Mexico Human Services Department (HSD) means the New Mexico State governmental agency responsible for the administration of the State of New Mexico's Medicaid Program pursuant to Title XIX of the Social Security Act.

B. "Standard" is defined in 45 C.F.R. §160.103.

C. "Provider" refers to any health care provider with a current State of New Mexico's Medicaid Program Provider ID number or any health care provider submitting an application to become a State of New Mexico's Medicaid Provider. "Provider" also includes all agents, subcontractors, or employees of State of New Mexico's Medicaid Provider.

D. "Transaction" is defined in 45 C.F.R. §160.103.

E. "Transactions and Code Set Regulations" mean those regulations governing the transmission of certain health claims transactions as promulgated by the U.S. Department of Health and Human Services in 45 C.F.R. Parts 160 and 162.

### **PROVIDER PARTICIPATION**

A. Provider will comply with all applicable provisions of the Social Security Act, as amended; federal or state laws, regulations, and guidelines; and HSD rules. Provider will limit the use or disclosure of information/data concerning State of New Mexico's Medicaid Program clients to the purposes directly connected with the administration of the State of New Mexico's Medicaid Program.

B. Provider will accept full legal responsibility for all claims submitted under the Provider's State of New Mexico's Medicaid Program ID number to the State of New Mexico's Medicaid Program and will comply with all federal and state civil and criminal statutes, regulations and rules relating to the delivery of benefits to eligible individuals and to the submission of claims for such benefits. Provider understands that non-compliance could result in no payment for services rendered.

C. Provider will request payment only for those services which are medically necessary or considered covered preventive services, and rendered personally by the Provider or rendered by qualified personnel under the Provider's direct and personal supervision. Claims will be submitted only for those benefits provided by health care personnel who meet the professional qualifications established by the State. Provider understands that any misrepresentation or falsification by another may result in fine and/or imprisonment under state or federal law.

D. Provider will maintain records that fully and accurately disclose the nature and extent of benefits provided to eligible clients/patients in accordance with the regulations of HSD. Provider will maintain licensure and/or certification granted by the State licensing agency that regulates the services that are provided, and will make disclosure of ownership and provide access to medical records and billing information to HSD, or its designees, as required by federal and state laws and regulations.

E. Provider records will be maintained for six (6) years unless an additional retention period is required under state or federal regulations, such as an audit started before the six (6) year period ended or based on a specific contract between the Provider and HSD.

## **Provider Participation Agreement – Continued**

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### **All applicants must complete**

F. The US Department of Health and Human Services, HSD, or the State Attorney General's Medicaid Fraud Control Unit, or their designees, has the right to audit and confirm for any purpose any information submitted by the Provider. Provider agrees to furnish information about submitted claims, any claim documentation records, and original source documentation; including provider and patient signatures, medical and financial records in the Provider's office or any other place, and any other relevant information upon request. Any and all incorrect payments discovered as a result of an audit will be adjusted or fully recovered according to the applicable provisions of the Social Security Act, as amended, federal or state laws, regulations, and guidelines.

G. Provider agrees to accept as payment in full, amounts paid in accordance with schedules established by HSD. No supplemental charges will be billed to the client, except for amounts designated as co-payments by HSD. Provider will not bill the client for any covered items or services that are reimbursable under the rules and regulations of HSD, or for any items or services that are not reimbursable but would have been had the Provider complied with the rules and regulations of HSD. All payments received or applied from any other sources will be recorded on the claim.

H. Provider certifies that items and services provided will be available without discrimination as to race, color, religion, age (except as provided by law), sex, marital status, political affiliation, handicap, or national origin. Provider hereby certifies compliance with Section 504 of the Rehabilitation Act of 1973 which provides that, "no otherwise qualified handicapped individual...shall, solely by reason of his/her handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance."

I. If, at any time from the date of this agreement, HSD determines that Provider has failed to maintain compliance with any state or federal laws, rules, or regulations, Provider may be suspended from participation in the Medical Assistance Program, and may be subjected to administrative actions authorized by federal or state law or regulation, criminal investigation, and/or prosecution.

J. HSD payment by electronic funds transfer (EFT) and advisement by deposit notice or remittance statement represents Provider's confirmation that funds were accepted for services rendered and billed.

K. Provider, and person signing the claim or submitting electronic claims on Provider's behalf, understands that failure to comply with any of the above in a true and accurate manner will result in any available administrative or criminal action available to HSD, the State Attorney General's Medicaid Fraud Control Unit, or other government agencies. The knowing submission of false claims or causing another to submit false claims may subject the persons responsible to criminal charges, civil penalties, and/or forfeitures.

## **GENERAL ELECTRONIC DATA INTERCHANGE TERMS AND CONDITIONS**

**(only applicable to those providers submitting and receiving data electronically)**

A. The Parties agree to submit claims and exchange data electronically using only those approved Transaction types and formats (versions) as selected by Provider within the Provider Enrollment Form.

B. For electronic claims, Provider will ensure that all required provider and patient signatures, including, where applicable, appropriate signatures on behalf of the patient, and required physician certifications are on file in the Provider's office.

### **Provider Participation Agreement – Continued**

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**All applicants must complete**

C. Transactions/documents will be transmitted electronically either directly or through a contracted third-party service provider, such as a vendor, billing agent, or clearinghouse. Provider may modify its election to use, not use, or change a third-party service provider by updating the Provider Enrollment Form. Provider will be responsible for the costs of any third-party service provider with which it contracts, and will ensure that any third-party service provider contracted will properly institute and adhere to those procedures reasonably calculated to provide appropriate levels of security for the authorized transmission of data, and protection from improper access. No Party accepts responsibility for technical or operational difficulties that arise out of third-party service providers' business obligations and requirements that undermine the Transaction exchange between Provider and Conduent.

D. The Parties will not change any definition, data condition, or use of a data element or segment in a Standard Transaction they exchange electronically, as per 45 C.F.R. §162.915.

E. The Parties will not add any data elements or segments to the maximum defined data set, as per 45 C.F.R. §162.915.

F. The Parties will not use any code or data elements that are either marked "not used" in a standard's implementation specification or are not in the standard's implementation specification(s), as per 45 C.F.R. §162.915.

G. The Parties will not change the meaning or intent of a Standard's implementation specification(s), as per 45 C.F.R. §162.915.

H. Conduent will accept Transactions from Provider according to the Provider Enrollment Form, but may subsequently deny a Transaction for further processing if the Transaction is not submitted using the data elements, formats or Transaction types set forth in the Provider Enrollment Form. Conduent may return Provider to a test status if Provider repeatedly submits Transactions that do not meet the criteria

set forth in the Provider Enrollment Form or if Provider repeatedly submits inaccurate or incomplete Transactions to Conduent.

I. Provider understands that Conduent or others may request an exception from the Transaction and Code Set Regulations from the U.S. Department of Health and Human Services. If an exception is granted, Provider will participate fully with Conduent in the testing, verification, and implementation of a modification to a Transaction affected by the change.

J. Provider and Conduent agree to keep open code sets being processed or used in this Agreement for at least the current billing period or any appeal period, whichever is longer, as per 45 C.F.R. §162.925(c)(2).

K. Transactions are considered properly received only after accessibility is established at the designated machine of the receiving Party. Once transmissions are properly received, the receiving Party will promptly transmit an electronic acknowledgement that conclusively constitutes evidence of properly received Transactions. Each Party will subject information to a virus check before transmission to the other Party.

L. Companion Guides are available in the Provider Services Specifications section of HSD's Web site at <http://www.hsd.state.nm.us/mad/5010HIPAAforNMMedicaidProviders.html>.

## Provider Participation Agreement - Continued

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**All applicants must complete**

### **ELECTRONIC CONFIDENTIALITY, PRIVACY AND SECURITY**

A. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy and Security Regulations (45 C.F.R. Parts 160 and 164) apply to all health plans, health care clearinghouses, and health care providers that transmit protected health information in electronic transactions; and extends to any business associate working on behalf of a covered entity. As such, it is expected that all Parties will implement and maintain appropriate policies, procedures, and mechanisms to protect the privacy and security of protected health information that is maintained by, and transmitted between, the Parties.

B. The Parties agree that any electronic protected health information furnished to one Party by any other Party will be used only as authorized under the terms and conditions of this Agreement and the Provider Enrollment Form, and may not be further disclosed. The Parties will establish appropriate administrative, technical, procedural, and physical safeguards to ensure the confidentiality, integrity, and availability of all electronic protected health information that is created, received, maintained, or transmitted as part of this Agreement. Provider will obtain satisfactory assurance and documentation thereof, as required by 45 C.F.R. §164.502(e), from any business associate with whom it contracts, and any subcontractors thereof, that all protected health information covered by this Agreement will be appropriately safeguarded.

C. Provider agrees that in the event HSD determines, or has a reasonable belief that Provider has made or may have made disclosure of State of New Mexico's Medicaid Program client protected health information that is not authorized by this Agreement, the Provider Enrollment Form, or other written HSD authorization, HSD, in its sole discretion, may require Conduent and/or Provider to: (a) promptly investigate and report HSD determinations regarding any alleged or actual unauthorized disclosure; (b) promptly resolve any problems identified by the investigation; (c) submit a formal written response to an

allegation of unauthorized disclosure; (d) submit a corrective action plan with steps designed to prevent any future unauthorized disclosures; and/or (e) return data to HSD.

## **ASSIGNMENT OF AGREEMENT**

- A. This Agreement is entered into solely between, and may be enforced only by the Parties. This Agreement shall not be deemed to create any rights in third parties or to create any obligations of the Parties to any third party.
- B. No Party may assign this Agreement without the prior written consent of HSD, and such consent may not be unreasonably withheld.

## **MODIFICATIONS**

- A. This Agreement contains the entire agreement between the Parties and supersedes any previous understanding, commitment or agreements, oral or written, concerning the electronic exchange of information/data. Any change to this Agreement will be effective only when set forth in writing and executed by all Parties.

## **Provider Participation Agreement - Continued**

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**All applicants must complete**

## **DISPUTES AND LIMITATION OF LIABILITY**

- A. This Agreement will be interpreted consistently with all applicable federal and state laws. In the event of a conflict between applicable laws, the more stringent law will be applied. This Agreement and all disputes arising from or relating in any way to the subject matter of this Agreement will be governed by and construed in accordance with New Mexico law, exclusive of conflicts of law principles. The exclusive jurisdiction for any legal proceeding regarding this agreement shall be in the courts of the State of Colorado and the Parties hereby expressly submit to such jurisdiction.
- B. Parties will use reasonable efforts to assure that the information – data, electronic files and documents supplied hereunder – are accurate. However, Provider shall indemnify, save, and hold harmless HSD, its employees and agents, against any and all claims, damages, liability and court awards including costs, expenses, and attorney fees incurred as a result of any act or omission by the Provider, or its employees, agents, subcontractors, or assignees pursuant to the terms of this Agreement
- C. Notwithstanding anything herein to the contrary, no term or condition in this Agreement shall be deemed, construed or interpreted as a waiver, express or implied, of any of the immunities, rights, benefits, protections, or provisions, of the New Mexico Governmental Immunity Act, NMSA Sections 41-13-1 et seq., as now or hereafter amended ("Immunity Act"), nor of the statuses governing the Risk Management Division of the New Mexico General Services Administration, NMSA Sections 15-7-1 et seq., as now or hereafter amended ("Risk Management Act"). The Parties understand and agree that the liability of the State of New Mexico, its departments, institutions, agencies, boards, officials and employees is controlled and limited by the provisions of the Immunity Act and the Risk Management Act, as now or hereafter amended. Any provision of this Agreement, whether or not incorporated herein by reference, shall be controlled, limited, and otherwise modified so as to limit any liability of the State to the above cited laws. In no event will the State be liable for any special, indirect, or consequential damages, even if the State has been advised of the possibility thereof.

D. DISCLAIMER OF WARRANTIES. THE PARTIES HEREBY EXCLUDE ALL EXPRESS AND IMPLIED WARRANTIES, INCLUDING BUT NOT LIMITED TO THE IMPLIED WARRANTIES OF MERCHANTABILITY AND THE IMPLIED WARRANTY OF FITNESS FOR A PARTICULAR PURPOSE. THERE ARE NO WARRANTIES WHICH EXTEND BEYOND THE DESCRIPTION OF THE FACE OF THIS AGREEMENT.

E. Provider warrants and represents that at the time of entering into this Agreement, neither Provider nor any of its employees, contractors, subcontractors or agents are identified on the HHS/OIG List of Excluded Individuals/Entities (available at <http://www.oig.hhs.gov/FRAUD/exclusions/listofexcluded.html>). In the event Provider or any employees, subcontractors or agents thereof becomes an ineligible person after entering into this Agreement or otherwise fails to disclose its ineligible person status, Provider shall have an obligation to immediately notify HSD of such ineligible person status and within ten days of such notice, remove such individual from responsibility for, or involvement with the Providers business operations related to this Agreement.

## Provider Participation Agreement - Continued

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All applicants must complete

### TERMINATION

A. This Agreement shall remain in effect until terminated by any Party with not less than thirty (30) days prior written notice to the other Parties. Such notice shall specify the effective date of termination. In the event of a material breach of this Agreement by Provider, as determined by HSD, HSD may terminate the Agreement by giving written notice to the breaching Provider. The breaching Provider shall have thirty (30) days to fully cure the breach. If the breach is not cured within thirty (30) days after the written notice is received by the breaching Provider, this Agreement shall automatically and immediately terminate.

B. This Agreement may be terminated by HSD if the contract between HSD and Conduent expires or terminates. Provider enrollment records will survive assignment of a new Department fiscal agent unless provider re-enrollment is explicitly initiated by HSD.

### TERM OF AGREEMENT

A. This Agreement is effective for the entire term of enrollment. This Agreement shall continue until terminated.

## Provider Participation Agreement - Continued

All applicants must complete

# PROVIDER SIGNATURE PAGE

**NO PROVIDER APPLICATION, ENROLLMENT FORM, PROVIDER AUTHORIZATION FORM (if applicable), OR PROVIDER PARTICIPATION AGREEMENT WILL BE PROCESSED WITHOUT COMPLETION OF THIS PAGE**

I certify by my signature below that I am fully authorized to sign and execute this Agreement on behalf of Provider; and that I have read, understand, certify, and agree to all the statements made above in all parts of this Provider Participation Agreement. I further understand that any false claims, statements, documents, or concealment of material fact may be grounds for termination as a State of New Mexico's Medicaid Program Provider, and/or may be prosecuted under applicable federal and state laws.

**Provider Name:** \_\_\_\_\_

**By:** \_\_\_\_\_

Provider/Provider Representative Signature  
(If the provider is an ICF/MR, by signing this update request, the ICF/MR agrees to the update changes only, the original ICF/MR agreement remains unchanged.)

**Name:** \_\_\_\_\_

Provider/Provider Representative Name (please print)

**Title:** \_\_\_\_\_

**NPI #:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Please return the completed EDI Provider Enrollment Application to the following address:**

E-Mail: [HIPAA.DeskNM@hsd.nm.gov](mailto:HIPAA.DeskNM@hsd.nm.gov)