

**DELAWARE TITLE XIX  
ELECTRONIC CLAIM SUBMISSION  
PROVIDER AGREEMENT**

TYPE OF  
AUTHORIZATION:

Please specify:    New <input type="checkbox"/> Change <input type="checkbox"/> Cancel <input type="checkbox"/>
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HP Enterprise Services, LLC has developed, under authority granted by the State of Delaware Medicaid Program, a claim processing system to facilitate business transactions by electronically transmitting and receiving data in lieu of conventional paper-based documents.

This Agreement is made by and between the State of Delaware’s Department of Health and Social Services, its fiscal agent, HP Enterprise Services (hereinafter referred to as HPES), and the undersigned provider (hereinafter referred to as Provider and/or Trading Partner):

Provider Group Name: _____
Group NPI: _____
Provider’s Address: _____ _____
Contact Person: _____
Contact Phone: _____
Email Address: _____

1. HPES operates and maintains, under the authority of the Department of Health and Social Services, a paperless transaction system that allows providers to submit electronic transactions through the use of designated electronic media in compliance with current HPES electronic claim specifications and any revisions that may occur from time to time.
2. The Trading Partner agrees that it will complete, to the specifications and satisfaction of HPES, adequate testing appropriate to the electronic transactions it intends to submit, and further agrees that it will correct transaction errors or deficiencies as identified by HPES.
3. The Trading Partner attests that all services for which reimbursement will be claimed shall be provided in accordance with all federal and state laws pertaining to the Delaware Medical Assistance Program, and that all charges submitted shall not exceed the Provider’s usual and customary charges for the same services and items provided to persons not entitled to receive benefits under the Delaware Medical Assistance Program.
4. The Trading Partner agrees that any payments made in satisfaction of claims submitted electronically will be delivered from federal and state funds and that any false claims, statements or documents, or concealments of a material fact may be subject to prosecution under federal and state law.

5. The Trading Partner shall allow HPES access to its claims data. Further, the Trading Partner shall take reasonable steps to insure that the claims data will be submitted only by authorized personnel.
6. The Trading Partner will institute and adhere to security procedures to prevent unauthorized access to data, data transmissions, security access codes, and any and all other private or protected data or records. Further, the Trading Partner will promptly notify HPES of any unlawful use or unintended disclosure of Protected Health Information or any unauthorized attempt to obtain access to or otherwise tamper with any protected data. In the event that any litigation arises concerning the unlawful or unauthorized disclosure or use of Protected Health Information, the Trading Partner will comply with requests for cooperation from HPES and the Department of Health and Social Services.
7. The Trading Partner agrees that electronic transmission of all data shall be in strict accordance with the standards set forth in this agreement; Electronic Claim Submission guidelines as put forth by HPES; and as defined by the Health Insurance Portability and Accountability Act. In the event that electronic transmission of data fails to comply with the above stated specifications, HPES may, with the approval of the Department of Health and Social Services, terminate this agreement upon written notice to the Trading Partner.
8. The Provider may modify its election to use, not use, or change a third-party service provider such as a billing agent or authorized vendor but understands that in the event that any such modification is made, it is incumbent upon the Provider to give written notice to HPES by submitting a new Trading Partner Agreement specifying that said change is being authorized. Regardless of any such change to a third-party service provider, all elements of this Trading Partner Agreement shall remain in effect and apply to all electronic transactions.
9. The Trading Partner understands and agrees that all other terms and conditions of participation in the Delaware Medical Assistance Program remain in effect and are unchanged by this Trading Partner Agreement.
10. Please specify if a billing agent or an authorized vendor will be used to submit claims:

APPROVED TRADING PARTNER	
Name of Vendor:	_____
Address:	_____
Contact:	_____
Telephone:	_____
Submitter ID:	_____

11. Please specify below the type(s) of electronic transaction(s) you intend to submit and specify for each of those transactions if a third-party service provider will be submitting or receiving electronic data on your behalf.

SPECIFY TRANSACTION(S)		PLEASE SPECIFY WHO WILL BE SENDING OR RECEIVING TRANSACTIONS.
<input type="checkbox"/>	837 Dental	Provider <input type="checkbox"/> Trading Partner <input type="checkbox"/>
<input type="checkbox"/>	837 Institutional	Provider <input type="checkbox"/> Trading Partner <input type="checkbox"/>
<input type="checkbox"/>	837 Professional	Provider <input type="checkbox"/> Trading Partner <input type="checkbox"/>
<input type="checkbox"/>	835 ERA	Provider <input type="checkbox"/> Trading Partner <input type="checkbox"/>
<input type="checkbox"/>	276/277	Provider <input type="checkbox"/> Trading Partner <input type="checkbox"/>
*	270/271*	Provider <input type="checkbox"/> Trading Partner <input type="checkbox"/>

\*270/271 transactions require completion and approval of the Eligibility Benefit Inquiry and Response Addendum.

Approved Trading Partner list: <http://www.dmap.state.de.us/downloads/software/Approved%20Vendors.pdf>

#### AUTHORIZATION TO SUBMIT ELECTRONIC CLAIMS

I hereby certify that I have examined this agreement and that the representations that are contained herein are true and correct. I hereby authorize the below stated individuals to submit electronic claims on my behalf to the State of Delaware Medicaid Program. I agree to notify HPES, in writing, of any changes to this agreement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

#### PERSONS AUTHORIZED TO SUBMIT CLAIMS ELECTRONICALLY:

I accept responsibility for the accuracy of electronic claims submitted to Medicaid and understand that any and all identification numbers used to submit electronic transactions are to remain confidential. I understand that failure to maintain confidentiality may result in falsified claims and may lead to criminal prosecution.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

#### DEPARTMENT OF HEALTH AND SOCIAL SERVICES:

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

#### Return Completed Form With Original Ink Signatures To:

HPES Enterprise Services, LLC  
 Suite 100, 248 Chapman Road  
 Newark, DE 19702

PLEASE CONTACT PROVIDER RELATIONS ECS TEAM AT 800-999-3371 OR DEXIX-PR-ECS@HP.COM WITH ANY QUESTIONS.