

Return this completed enrollment packet to:
 ATTN: TPL Analyst
 HP Enterprise Services, LLC Provider Enrollment
 PO Box 909
 New Castle DE 19720

<u>Do not write here</u>		
Enrollment Tracking #		
Sanction	DUPL	HP Enterprise
Services, LLC		
Entered:		Effective:
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Delaware Medical Assistance Enrollment Packet
Private Health Insurance Data Exchange
Taxonomy: 305S00000X

Welcome to the Delaware Medical Assistance Program. This enrollment packet has been prepared for use by Private Health Insurance Companies enrolling for the purpose of data exchange. This packet is divided into three parts: 1. Cover Page, 2. Private Health Insurance Data Exchange, Memorandum of Understanding (MOU), 3. W-9 form.

To complete the application process, you will need the following *required* documents.

- ___ Completed Cover Page
- ___ Private Health Insurance Data Exchange, Memorandum of Understanding (MOU) (Five signed copies – **First 2 Pages ONLY**)
- ___ W-9 Form
- ___ Copy of your Delaware Certificate of Authority
- ___ Organizational Chart that depicts the company’s national name and its subsidiaries.

Before you begin filling out this enrollment packet, first complete the W-9 form that is included at the end the packet. This is a four-page form that includes directions for completion. It must be signed and dated by the company representative. You will use the name, address, and Tax ID number entered on the W-9 to complete your enrollment.

Once you have assembled and completed all of the required materials, take a moment to check off each of the pieces listed above. Incomplete applications are returned to the company. Please make sure that you have remembered to sign and date all forms.

Make a copy of this enrollment packet for your records. Send the original to HP Enterprise Services, LLC to the address at the top of this page. If you have questions about completing this packet, or about the status of your application, call HP Enterprise Services, LLC Provider Relations at: 1-800-999-3371 and ask for the TPL Analyst.

Company Name: _____

Company Address: _____

Company Contact Name: _____ Phone: _____

Tax ID Number: _____

Delaware Certificate of Authority Number: _____

- Business Type - _____
- Government Owned
 - Business Corp. for profit
 - Business Corp. non-profit
 - Private – for profit
 - Private – non-profit
 - Partnership
 - Trust

Private Health Insurance Data Exchange

Memorandum of Understanding

This memorandum of understanding (MOU) is entered into between the Delaware Division of Medicaid and Medical Assistance (DMMA), and the Insurance Company identified on the signature page of this MOU.

The purpose of this agreement is to establish the responsibilities of each party as it pertains to the administrative functions of Title 18 § 4006 of the Delaware Code. This legislation implements a requirement of the Federal Deficit Reduction Act (DRA) of 2005.

DMMA is authorized to require the designated health insurer to provide, upon request eligibility and coverage information (including, but not limited to the name, address, date of birth, social security number, policy number, group identification number, types of covered services under the policy, effective dates of coverage, and termination date for each client). This information will enable DMMA to determine during what period Medicaid recipients may be or may have been covered by the health insurer and the nature of the coverage that is or was provided. This information shall be referred to as the Plan Eligibility Data Elements.

This MOU is subject to the following terms and conditions:

1. Responsibility

Delaware Division of Medicaid and Medical Assistance (DMMA)

- A. DMMA will provide the insurance carrier with the electronic file format required.
- B. DMMA will provide the insurance carrier with the method of delivery necessary for DMMA to receive the eligibility file on a monthly basis.

Insurance Company

- A. The insurance company will submit a full file of client Plan Eligibility Data Elements covering the 3 years prior to the date of file submission in the required file format to DMMA by the 15th of each month.
- B. The insurance company will enroll as an Atypical Provider for DMMA in order to submit the monthly file via the web in the manner available to DMMA. When the new process for file submission has been completed DMMA will inform the provider of the necessary change. At that time the designated insurance company will be disenrolled as an Atypical Provider with DMMA.
- C. The designated insurance company will make available all records of activities associated with Medicaid eligible clients for review on request by DMMA or other entities as directed by DMMA.

2. Data Elements

The data elements to be included on the electronic file are found in Appendix A of the MOU. Additional tables to be used as reference for field values are found in Appendix B.

3. Period of Agreement

This MOU is effective as of the date it is signed by all parties and shall continue as long as Title 18 § 4006 of the Delaware Code is in effect. This agreement may be amended at any time upon mutual consent of both parties consistent with Title 18 § 4006 of the Delaware Code.

4. Liability for Data Provision

As provided in Title 18 Section 4006 of the Delaware Code, no health insurer that provides data required by DMMA, whether confidential or not, shall be held liable for the provision of such data to DMMA or for any use made thereof. DMMA shall have procedures in place to ensure compliance with the requirements of the Health Insurance Portability and Accountability Act of 1996 relating to the privacy and security of individually identifiable health information, as applicable.

Authorized Signers:

Rosanne Mahaney, Acting Director
Division of Medicaid and Medical Assistance
Department of Health and Social Services
State of Delaware

Date

Rita Landgraf, Secretary
Department of Health and Social Services
State of Delaware

Date

Insurance Company Representative

Date

Name and Title of Individual Signing the MOU

Name of the Insurance Company

Appendix A

The data elements to be included on the electronic file are;

Field Name	Field Length	Field Type	Description
HD Record			
RECORD-TYPE	2	ALPHA-NUMERIC	Record type indicator with a value of HD
DESCRIPTION	50	ALPHA-NUMERIC	Record description with a value of TPL HEADER FROM CARRIER
TRANSACTION-ID	8	ALPHA-NUMERIC	TPXP810
CREATE-DATE	8	NUMERIC	File creation date in CCYYMMDD format
LD Record			
RECORD-TYPE	2	ALPHA-NUMERIC	Record type indicator with a value of LD
MA-NUMBER	10	ALPHA-NUMERIC	Medicaid ID number for client/dependent; only the most current ID number is sent. Leave blank if not available.
LAST-NAME	30	ALPHA-NUMERIC	The client's last name. This field is required.
FIRST-NAME	20	ALPHA-NUMERIC	The client's first name. This field is required.
MIDDLE-INITIAL	1	ALPHA-NUMERIC	The client's middle initial.
SUFFIX	4	ALPHA-NUMERIC	The client's suffix. (Jr., Sr. etc.)
HIC	12	ALPHA-NUMERIC	Medicare ID number
SSN	9	NUMERIC	The client's 9-digit social security number. This field is required.
DATE-OF-BIRTH	8	NUMERIC	The client's/dependent's DOB (CCYYMMDD Format) This field is required.
SEX-INDICATOR	1	ALPHA-NUMERIC	The client/dependent's gender (M - Male, F - Female, U - Unknown) This field is required.
ADDRESS-1	25	ALPHA-NUMERIC	The client/dependent's address line 1
ADDRESS-2	25	ALPHA-NUMERIC	The client/dependent's address line 2
CITY	20	ALPHA-	The client/dependent's City

		NUMERIC	
STATE	2	ALPHA- NUMERIC	The client/dependent's State
ZIP	9	NUMERIC	The Client/dependent's address Zip Code + 4. If the last 4 digits are not known default them to 0000.
DEP-CODE	10	ALPHA- NUMERIC	Code to uniquely identify a member within a family if the carrier identifies client individually within the policy. (if available) Example: 01, 02, or 03.
EXHAUST INDICATOR	1	ALPHA- NUMERIC	Y or N if the benefit has been exhausted.
POLICY-NUMBER	18	ALPHA- NUMERIC	The ID number of the primary insured. This field is required.
POLICY-GROUP	17	ALPHA- NUMERIC	The group number of the TPL segment. This is the number associated with the Company that employs or provides coverage for the policyholder.
POLICY-TYPE	3	NUMERIC	Type of insurance policy. Refer to attached Table 1 for valid values. This field is required.
COVERAGE-CODE	4	NUMERIC	Coverage Code indicates which medical areas, such as physician services, vision coverage, and dental coverage, are covered by the policy. Refer to attached Table 2 for valid values. This field is required.
MEMBER-ID	17	ALPHA- NUMERIC	The dependent ID if different from the policyholder (02, 03 etc.). Most cases will be identical to the Dep-Code.
LIM-DISC-INDICATOR	2	NUMERIC	Indicator for limited coverage types that may/may not be billed by Medicaid. Valid values are below: 01 - accident 02 - dental 03 - vision 04 - EAP 05 - indemnity 06 - discount
ANNUAL-CAP	9	NUMERIC	Maximum amt of insurance benefit, 9999999.99 (decimal point is implied).
PLAN-TYPE-INDICATOR	2	NUMERIC	Indicates what type of plan. 01 - HMO

			02 - PPO 03 - POS 04 - Medicare Supplemental
DRUG-CARRIER-NAME	45	ALPHA-NUMERIC	Name of drug carrier if policy/plan is outsourced.
DRUG-POL-EFF-DATE	8	NUMERIC	Date the drug policy went into effect. (CCYYMMDD Format)
DRUG-POL-TERM-DATE	8	NUMERIC	Date the drug policy is terminated. (CCYYMMDD Format) If the policy is open ended use default value 99991231.
MENTAL-HEALTH-CARRIER-NAME	45	ALPHA-NUMERIC	Name of MH Carrier if policy/plan is outsourced
POL-HLDR-LAST-NAME	30	ALPHA-NUMERIC	The policyholder is the individual; often the mother or father of a family, in whose name the policy is held. This field is required.
POL-HLDR-FIRST-NAME	20	ALPHA-NUMERIC	The policyholder is the individual; often the mother or father of a family, in whose name the policy is held. This field is required.
POL-HLDR-MI	1	ALPHA-NUMERIC	The policyholder is the individual; often the mother or father of a family, in whose name the policy is held.
POL-HLDR-SSN	9	NUMERIC	The SSN of the policyholder. This field is required.
POL-HLDR-ADDR-STR1	25	ALPHA-NUMERIC	The first line of the policyholder address.
POL-HLDR-ADDR-STR2	25	ALPHA-NUMERIC	The second line of the policyholder address (optional).
POL-HLDR-ADDR-CITY	20	ALPHA-NUMERIC	The city of the policyholder address.
POL-HLDR-ADDR-STATE	2	ALPHA-NUMERIC	The State of the policyholder address.
POL-HLDR-ADDR-ZIP	9	NUMERIC	The zip code of the policyholder address. (Zip + 4). If the last 4 digits are not known default them to 0000.
POL-HLDR-DOB	8	NUMERIC	The date of birth of the policyholder (CCYYMMDD Format)
POL-HLDR-SEX	1	ALPHA-NUMERIC	The gender of the policyholder (M - Male, F - Female, U - Unknown)
POL-HLDR-EFF-DATE	8	NUMERIC	The effective date of the policy. (CCYYMMDD Format) This field is required.

POL-HLDR-TERM-DATE	8	NUMERIC	The termination date of the policy. (CCYYMMDD Format) If the policy is open ended use default value 99991231. This field is required.
DEDUCT-AMOUNT	9	NUMERIC	The deductible amount the policy requires the client to pay. 9999999.99 . This value may equal zero. (decimal point is implied)
COPAY-AMOUNT	9	NUMERIC	Amount of co-pay the policy requires the client to pay at the time of service. 9999999.99 . This value may equal zero. (decimal point is implied)
COINS-AMOUNT	9	NUMERIC	Amount of coinsurance the policy requires the client to pay for services. 9999999.99 . This value may equal zero. (decimal point is implied)
LST-CHG-DATE	8	NUMERIC	Last changed date for the insurance policy information. (CCYYMMDD format) This field is required.
ORIG-CLIENT-EFF-DATE	8	NUMERIC	Date the client became covered by the policy. (CCYYMMDD format) This field is required.
CLIENT-END-DATE	8	NUMERIC	Date the client is no longer covered by the policy. (CCYYMMDD format) If the client has an open ended segment use default value 99991231. This field is required.
RELATIONSHIP	2	ALPHA-NUMERIC	Relationship Code - how the client is related to the Policy Holder. Refer to attached Table 3 for valid values. This field is required.
SUBROGATION	2	NUMERIC	Some clients have more than one source of other insurance coverage. Refer to attached Table 4 for valid values. This field is required.
ORIGIN	1	ALPHA-NUMERIC	This field identifies the source from which Medicaid acquired information about a client having other insurance coverage. A default value will be provided.
VERIFICATION-IND	1	ALPHA-NUMERIC	If the client's TPL information has been verified. (Y/N) This field should be defaulted to 'Y'.

VERIFICATION-DATE	8	NUMERIC	This date field contains zeroes when the verification indicator = N. (CCYYMMDD format) This field should be defaulted to the file creation date.
DTL-STATUS	1	ALPHA-NUMERIC	The TPL information status. This field should be defaulted to 'A' for Active.
EMPLOYER-NAME	25	ALPHA-NUMERIC	This field may contain spaces.
EMPLOYER-CODE	7	NUMERIC	This field may contain spaces. This field will currently be left blank.
EMPLR-ADDR-STR1	25	ALPHA-NUMERIC	The first line of the employer address. This field may contain spaces.
EMPLR-ADDR-STR2	25	ALPHA-NUMERIC	The second line of the employer address. This field may contain spaces.
EMPLR-ADDR-CITY	20	ALPHA-NUMERIC	The city of the employer address. This field may contain spaces.
EMPLR-ADDR-STATE	2	ALPHA-NUMERIC	The State of the employer address. This field may contain spaces.
EMPLR-ADDR-ZIP	9	NUMERIC	The zip code of the employer address. (Zip + 4) If an employer address is not available, this field will contain zeroes. If the last 4 digits are not known default them to 0000.
CARR-CODE	5	ALPHA-NUMERIC	The carrier code. A crosswalk value will be provided. This field is required.
CARR-LOCATION	4	ALPHA-NUMERIC	The carrier location. A crosswalk value will be provided. This field is required.
CARR-TYPE	2	ALPHA-NUMERIC	The carrier type. Use default value 'H' for Health Insurance. This field is required.
CARR-NAME	45	ALPHA-NUMERIC	The name of the carrier. A crosswalk value will be provided. This field is required.
NEIC-IND	1	ALPHA-NUMERIC	Y - NEIC carrier, N - Non-NEIC carrier

STATUS	1	ALPHA- NUMERIC	The status of the carrier. A - Active Should always be A-ACTIVE
CLM-SUB-ADDR- STR1	20	ALPHA- NUMERIC	The first line of the carrier claim submission address. This field is required.
CLM-SUB-ADDR- STR2	20	ALPHA- NUMERIC	The second line of the carrier claim submission address. This field may contain spaces.
CLM-SUB-ADDR- CITY	20	ALPHA- NUMERIC	The city of the carrier claim submission address. This field is required.
CLM-SUB-ADDR- STATE	2	ALPHA- NUMERIC	The State of the carrier claim submission address. This field is required.
CLM-SUB-ADDR-ZIP	9	NUMERIC	The zip code of the carrier claim submission address. (Zip + 4) If the last 4 digits are not known default them to 0000. This field is required.
CONTACT-PHONE	10	ALPHA- NUMERIC	This is the carrier's phone number.
BILLING-MEDIA	1	ALPHA- NUMERIC	Refer to attached Table 5 for valid values.
BILLING-FORM	1	ALPHA- NUMERIC	Refer to attached Table 6 for valid values.
EXTERNAL-PROV-ID	13	ALPHA- NUMERIC	The provider ID assigned to Medicaid by the insurance carrier. (if available)
EXTERNAL- ACCOUNT-NUM	15	ALPHA- NUMERIC	The account number assigned to Medicaid by the insurance carrier. (if available)
CLAIM-FILING-LIMIT	3	NUMERIC	The carrier's claim filing limit.
TR Record			
RECORD-TYPE	2	NUMERIC	Record type indicator with a value of TR
DESCRIPTION	50	ALPHA- NUMERIC	Record description with value of TPL TRAILER FROM CARRIER
TOTAL-TXNS	8	NUMERIC	Total number of records on file including header and trailer records

* For non-required fields, if no data is available then the field should be populated with spaces or zeros.

Appendix B

Table 1 - POLICY-TYPE

Code	Description
001	MCO
002	Military Health (CHAMPUS)
003	Traditional Health
004	Limited Health
005	Medicare Supplement
006	Medicare Part A
007	Medicare Part B
008	Railroad Retirement
009	Medicare HMO
010	PPO
011	Specific Health
012-019	Intentionally left blank for future use.
020	Medicare Part D
021	Homeowner's
022	Automobile
023	Commercial Property
024	Worker's Compensation
025-030	Intentionally left blank for future use.
031	Other

Table 2 - COVERAGE-CODE

Code	Description
0001	Full Coverage
0002	Full Coverage without Dental
0003	Full Coverage without Dental & Drugs
0004	Full Coverage without Vision
0005	Full Coverage without Dental & Vision
0006	Accident Policy
0007	Hospital Policy
0008	Surgical Policy
0009	Accident & Hospital Policy
0010	Cancer Policy
0011	Dental Policy
0012	Drug Only
0013	Vision
0014	Medicare Part A
0015	Medicare Part B
0016	Medicare Supplement - No Drugs
0017	Hospital with Medical – Surgical Riders
0018	Medicare Supplement with Drugs
0019	Full Coverage w/o office visits
0020	Medicare Part D
0021	Full Coverage - No Drugs – No LTC
0023	Full Coverage w/o visits, dental, vision or drugs
0024	Full Coverage w/o vision or drugs

Code	Description
0025	Full Coverage - No Dental - No Vision - No Drugs
0026	Full Coverage w/o office visits or drugs
0027	Medicare HMO
0029	Unknown
0030	Full Coverage w/o office visits, vision or drugs
0031	Full Coverage w/o office visits, vision or dental
0032	Full Coverage w/o office visits and dental
0033	Full Coverage w/o visits-dental-mental health svc
0034	Full Coverage w/o dental-vision-mental health svc
0035	Mental Health policy only
0036	Nursing Home policy only
0037	Workman's Compensation policy only
0038	Blood Bank policy
0039	Medical-Surgical w/o visits-dental-vision-drugs
0040	Part A Medicare Supplement
0041	Part B Medicare Supplement
0042	Never Cost Avoid Criteria (TPNC)
0043	Pay and Chase Criteria (TPNP)

Table 3 - RELATIONSHIP

Code	Description
01	Spouse
04	Grandfather or Grandmother
05	Grandson or Granddaughter
07	Nephew or Niece
10	Foster Child
15	Ward
17	Stepson or Stepdaughter
18	Self
19	Child
20	Employee
21	Unknown
22	Handicapped Dependent
23	Sponsored Dependent
24	Dependent of a Minor Dependent
29	Significant Other
32	Mother
33	Father
36	Emancipated Minor
39	Organ Donor
40	Cadaver Donor
41	Injured Plaintiff
43	Child where Insured has no Financial Responsibility
53	Life Partner
G8	Other Relationship

Table 4 - SUBROGATION

Code	Description
05	Casualty-Worker Compensation-Litigation
10	Health Insurance Through an Employer
15	Health Insurance Through a 2nd Employer
20	Health Insurance by Spouse's Employer
25	Child Hlth Ins by Both-Early Bday Primry
30	Child Hlth Ins by Both-Later Bday 2ndary
35	Divorced - Insured Parent w/Custody
40	Divorced - Insured Parent w/o Custody
45	Insured Step-Parent
50	Group Insurance and Medicare
55	Individual Health Insurance
60	Medicare Supplement
65	Medicaid Coverage in Another State

Table 5 - BILLING-MEDIA

Code	Description
E	Electronic
P	Paper
B	Both

Table 6 - BILLING-FORM

Code	Description
A	ANSI 837 (Electronic Clm)
C	Claim Facsimile
D	Claim Specific Profile
F	Insurance Prem Recovery
N	NCPDP
P	Proprietary

BILLING-FORM and BILLING-MEDIA Cross-reference

Billing-Form	Billing-Media
A	E
C	B
D	P
F	P
N	B
P	B