INTEGRANET HEALTH TPA SERVICES
EDI REGISTRATION INFORMATION

Frequently Asked Questions

- **I would like to submit claim transactions (837I or 837P) and/or download an electronic remittance file (835) via the IntegraNet Health TPA Services Provider Portal. What forms are required?**

  - IntegraNet Health TPA Services Trading Partner Agreement. (pgs. 2-3)
  - IntegraNet Health TPA Services EDI Registration form. (pgs. 4-5)

- **I would like to receive claims payments by Electronic Funds Transfer (EFT). What form is required?**

  - IntegraNet Health TPA Services Electronic Funds Transfer (EFT) Agreement form. (pgs. 6-7)

- **I would like to submit claim transactions (837I or 837P), download an electronic remittance file (835) and receive claims payments by Electronic Funds Transfer (EFT). What forms are required?**

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- **Who do I contact if I have questions regarding these forms?**

  - Email your questions to EDI@abctservices.com

- **Where do I send the completed forms for processing?**

  - Fax to 832-320-7221
  - Though the ticketing system to www.InetClaims.zendesk.com
  - Mail to:

IntegraNet Health TPA EDI Services
1900 N. Loop West, Ste 400
Houston, Texas 77018

INTEGRANET HEALTH TPA SERVICES
TRADING PARTNER AGREEMENT

This agreement is made by and between ABCT, Inc. as an IntegraNet Health Plan TPA (Hereinafter "PLAN TPA") and _____
(Name of Provider or Electronic Billing Service) (Hereinafter "Trading Partner")

Relative to the electronic transmission of health information in connection with a transaction covered by 45 CFR Parts 160 and 162 that is exchanged between the Trading Partner and the Plan TPA, its fiscal agent.
The Trading Partner agrees to the following:

1. The Trading Partner holds the Plan TPA harmless and indemnifies against any liability to the Trading Partner, the Plan TPA or any Provider arising out of the entering into this agreement or electronic transmission of health information in connection with claims submitted electronically.

2. The Trading Partner will prepare and submit electronic submissions in conformance with state and federal regulations, to the extent that – specific data elements do not change the meaning or intent of any of the Health and Human services (HHS) Transaction Standard's implementation specifications or do not change any definition, data condition or use of data element or segment as set forth in the HHS Transaction Standard Regulation. (45 CRT Part 162, Subparts I through N). Trading Partner further agrees that it will not change any definition, data condition or use of data element or segment nor add any data elements or segments to the maximum data set as proscribed in the HHS Transaction Standard Regulation.

3. Trading Partner shall adequately test all business rules appropriate to their types and specialties with the Plan TPA. Trading Partner further agrees and understands that HHS may modify and set compliance dates for the HHS Transaction Standards modifications. Trading Partner agrees to incorporate by reference into the Agreement any such modifications or changes. (45 CFR *160.104).

4. Trading Partner agrees to comply with all applicable privacy and security standards as set forth in (45 CFR Parts 160,162, and 164).

5. If the Plan TPA determines that Trading Partner submissions fail to conform to Plan TPA Companion Guides and the HHS Transaction Standard's implementation specifications as set forth HHS Transaction Standard Regulation (45 CFR Part 162, Subparts I through N), the Plan TPA may Terminate this agreement (5) working days after the Trading Partner has received a written termination notice.

6. This Agreement shall survive in the event the contract between the Plan TPA and its current fiscal agent expires or terminates and shall be valid with regard to future fiscal agents unless otherwise modified or terminated.

AUTHORIZED SIGNATURE OF TRADING PARTNER _____

DATE: _____

AUTHORIZED SIGNATURE OF PLAN TPA: _____

DATE: _____

INTEGRANET HEALTH TPA SERVICES

EDI REGISTRATION FORM

Please check one:

☐ I am requesting access to the IntegraNet Health TPA Services Provider Portal

☐ I am updating existing access to the IntegraNet Health TPA Services Provider Portal

☐ I am removing/terminating access to the IntegraNet Health TPA Services Provider Portal

1. TAX INFORMATION (One Tax ID per EDI Enrollment Form. For additional TAX IDs, you must complete a separate EDI Enrollment Form).

TAX ID #:

2. CONTACT INFORMATION

Office/Clinic/Facility Name:			
Physical Address:	City:	State:	Zip:
Mailing Address:	City:	State:	Zip:
Primary Contact Name: Phone: Email:			
Secondary Contact Name: Phone: Email:			
Please list any questions or comments here:			

3. TRADING PARTNER INFORMATION

Trading Partner Name:			
Address:	City:	State:	Zip:

INTEGRANET HEALTH TPA SERVICES

EDI REGISTRATION FORM

4. PROVIDER INFORMATION

Provider Name	Provider NPI

***Please use a new form for additional providers.**

Note: The 977 Functional Acknowledgements and the Submission Accept/Reject Report will automatically be available for download by the Trading Partner identified as the Submitter. The 835 transactions will be sorted by the Pay-To Provider, and will require specific instructions as the identity of the Trading Partner who will be authorized to download them.

INTEGRANET HEALTH TPA SERVICES ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I – REASON FOR SUBMISSION

Reason for Submission: ☐ New EFT Authorization
☐ Revision to Current Authorization (*e.g. account or bank changes*)

Chain Home Office Organization: ☐ Check here if EFT payment is being made to the Home Office of Chain (*Attach letter authorizing EFT payment to Chain Home Office*)

PART II – PROVIDER OR SUPPLIER INFORMATION

Name _____

Provider/Supplier Legal Business Name _____

Chain Organization Name _____

Home Office Legal Business Name (*if different from Chain Organization Name*)

Tax Identification Number: (Designate ☐ SSN or ☐ EIN) _____

Medicare Identification Number *(If issued)* _____

National Provider Identifier (NPI) _____

PART III – DEPOSITORY INFORMATION (Financial Institution)

Depository Name _____

Street Address _____

City _____ State _____ Zip Code _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number (*nine digit*) _____

Depositor Account Number _____

Type of Account (*check one*) ☐ Checking Account ☐ Savings Account

Please include a voided check or deposit slip or confirmation of account information on bank letterhead. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type, and bank officer's name signature. This information will be used to verify your account number.

PART IV – CONTACT PERSON

First Name	Middle Initial	Last Name
Telephone Number		Fax Number *(if applicable)*
Address Line 1 *(Street Name and Number)*		
Address Line 2 *(Suite, Room, etc.)*		
City/Town	State	Zip Code + 4
E-mail Address		

PART V- AUTHORIZATION

I hereby authorize the Health Plans, hereinafter called the CONTRACTOR, to initiate credit entries, and in accordance with 31 CFR part 210.6(f) initiate adjustments for any credit entries made in error to the account indicated above. I hereby authorize the financial institutions/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If payment is made to an account controlled by a Chain Home Office, the Provider of Services hereby acknowledges that payment to the Chain Office under these circumstances is still covered payment to the Provider, and the Provider authorizes the forwarding of the Health Plan payments to the Chain Home Office.

If the account is drawn in the Physician's or Individuals PRACTITIONER'S Name, or the Legal Business Name of the Provider/Supplier, the said Provider or Supplier certifies that he/she has sole control of the account referenced above, and certifies that all arrangements between the DESPSITORY and the said Provider or Supplier are in accordance with all applicable Medicare regulations and instructions.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the CONTRACTOR has received written notification from me of its termination in such time and such manner as to afford the CONTRACTOR and the DEPOSITORY reasonable opportunity to act on it. The CONTRACTOR will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change CONTRACTOR and updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name (Print) _____

Authorized/Delegated Official Title _____

Authorized/Delegated Official Signature _____ Date _____

I understand in receiving Electronic Funds Transfers that payment may be from Federal and State funds and that any falsification, or concealment of a material fact, may be prosecuted under Federal and State laws.

PRIVACY ACT ADVISORY STATEMENT

Sections 1842, 1862(b) and 1874 of title XVIII of the Social Security Act authorize the collection of this information. The purpose of collecting this information is to authorize electronic funds transfers.