



## Trading Partner Profile

In order to expedite the set up process, please fill out the following fields completely. Once complete, please email this form to roses@healthplan.org.

**General Information:**

<b>Trading Partner Name:</b>			
<b>Street Address:</b>			
City/State/ZIP Code:			
<b>Main Telephone Number:</b>			
<b>Main Fax Number:</b>			
<b>Website URL:</b>			
<b>Companion Guide Location:</b>	NA		
<b>Trading Partner Type:</b>	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Commercial

**Testing Contact Information:**

This will be our main contact for testing information and results.

<b>Testing Contact Name:</b>	Rose Sarcopski
Title:	EDI Support Center
Telephone:	800-624-6961 Ext 6189 or 740-699-6189
Fax:	740-695-5297
E-mail:	roses@healthplan.org

**Operations Contact Information:**

This will be our main contact for transmission and connection issues.

<b>Operations Contact Name:</b>	Rose Sarcopski
Title:	EDI Support Center
Telephone:	800-624-6961 Ext 6189 or 740-699-6189
Fax:	740-695-5297
E-mail:	roses@healthplan.org

**Enrollment Contact Information:**

If enrollment / re-enrollment of our providers will be required in order to send HIPAA compliant transactions, please fill out the grid below. This will be our main contact for provider enrollment issues.

<i>Enrollment Contact Name:</i>			
Title:			
Street Address:			
City/State/ZIP Code:			
Telephone:			
Fax:			
E-mail:			

**EDI Enveloping Information:**

Utilize the following grid to outline the enveloping information that you require for inbound electronic transactions.

Interchange ID Qualifier (ISA05):	ZZ
Interchange Sender ID (ISA06) Tax ID	
Interchange ID Qualifier (ISA07):	ZZ
Interchange Receiver ID (ISA08):	Healthplan
Application Sender's Code (GS02) Tax ID	
<b>Application Receiver's Code (GS03):</b>	Healthplan
<b>Submitter ID (NM1*41, 1000A loop) Tax ID:</b>	
Receiver Name (NM1*40, 1000B loop):	
<b>Receiver ID (NM1*40, 1000B loop):</b>	
<b>Payer Identifier (NM1*PR, 2010BB loop):</b>	
Our standard business practice is to send one transaction set per file including all claims from all providers. Will this meet your needs? If not, please describe your requirements in the space provided.	<input type="checkbox"/> Yes <input type="checkbox"/> No (details below) <hr/> <hr/> <hr/> <hr/>
Maximum number of claims per production file:	10,000 per HIPAA

**Delimiter Information:**

Utilize the grid below to indicate the delimiters you require for inbound transactions.

<i>Segment Terminator:</i>	
Element Separator:	
Sub-Element Separator:	

**Testing Requirements:**

Utilize the grid below to outline your inbound testing requirements.

<b>Minimum number of claims per test file:</b>	10 Claims
Maximum number of claims per test file:	1,000 Claims
Which specialties will need to be tested?	No specific specialties
Will each provider need to be tested separately?	No
Will providers need to be enrolled prior to testing?	No
What is the expected turn around time for results?	10 Business Days
Will reports be the same in production as they are in test?	Yes
What is your estimated Go-Live Date?	
Actual Go-Live Date <i>(Internal Use Only)</i>	

**Additional Information:**

If there are any special requests that are not outlined in your companion guide, or that you would like to call extra attention to, please list them in the box below.

The Health Plan  
52160 National Road East  
St. Clairsville, OH 43950  
(800)624-6961 Ext 7649

## **Electronic Data Interchange Trading Partner Agreement**

This Electronic Data Interchange Trading Partner Agreement (“Agreement”) is made as of this \_\_\_ day of \_\_\_\_\_, 2008 by and between \_\_\_\_\_ (“Submitter”) and The Health Plan of the Upper Ohio Valley (“The Health Plan”).

1. Submitter is a Covered Entity as defined in the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (“HIPAA”). THE HEALTH PLAN acts as a Business Associate, as defined in HIPAA, of certain health care providers that receive payment for health care claims from The Health Plan and that have requested that The Health Plan send payments, and data in electronic form related to such payments, to \_\_\_\_\_ (“Submitter”).
2. This Agreement sets forth the terms and conditions on which Submitter and THE HEALTH PLAN will exchange data in electronic form on behalf of Providers. The data in electronic form that will be exchanged by Submitter and THE HEALTH PLAN is referred to herein as a “Transaction” or “Transactions.”
3. Submitter and THE HEALTH PLAN will complete an Exhibit A in the form attached hereto for each Provider for which they will exchange Transactions, including the types of Transactions to be exchanged for that Provider. The parties will update Exhibit A as Transactions are added or deleted for the Provider.
4. THE HEALTH PLAN will provide to Submitter the technical requirements related to the exchange of Transactions. As to software, equipment, and services associated with each party’s performance under this Agreement, the parties agree to reasonably cooperate with each other in order to provide support services sufficient to meet HIPAA security requirements for Transactions as contemplated herein. Each party will reasonably assist the other in establishing and/or maintaining support procedures, and will complete reasonable problem determination procedures prior to contacting the other with a support-related matter. The parties agree to use reasonable efforts to avoid and resolve performance and unavailability issues. Each party shall, at no professional service charge to the other, perform consultation on the design and implementation of the connection to the other party and test the connection prior to validating it. If any Transaction is received in an unintelligible or garbled form, the receiving party, if feasible, shall notify the originating party as soon as determined. Each party will perform commercially reasonable remedial actions as requested by the other to assist in problem resolution. Each party agrees to notify the other within a reasonable time of the existence of any condition which might have an adverse effect on the parties’ ability to transmit or process Transactions. Nothing in this Agreement shall require a party to disclose to the other party any process, method or other information that is a trade secret or confidential or proprietary.
5. THE HEALTH PLAN and Submitter shall each be responsible for obtaining from Providers authorization to transmit Transactions to the other party. Each party may further transmit or otherwise use Transactions to provide additional services to Providers as agreed upon separately between such party and the Providers, and shall be responsible for obtaining from Providers their authorizations for such other or additional use.
6. Submitter and THE HEALTH PLAN will each implement appropriate policies and procedures for purposes of preventing unauthorized access to, and unauthorized disclosure of, Transactions. THE HEALTH PLAN represents that it has signed a Business Associate Agreement with each Provider for

which it will exchange Transactions with Submitter under this Agreement, requiring it to protect the confidentiality of Protected Health Information, as defined in HIPAA, in accordance therewith.

7. Each party agrees to retain copies of the Client Information for at least the period of time required by the law applicable to such party.

8. Each party warrants that it has obtained from the Providers and from any other party all necessary consents, approvals and other rights that it is required by law to obtain for the possession, transmission or other use of the Transactions. Each party warrants that it is capable of performing its respective responsibilities under this Agreement and that they shall be performed in a professional, competent and workmanlike manner. Neither Submitter nor THE HEALTH PLAN makes any warranty with respect to the accuracy or correctness of the Transactions. **THE WARRANTIES SPECIFICALLY SET FORTH ABOVE ARE IN LIEU OF ALL OTHER WARRANTIES, EXPRESS OR IMPLIED, INCLUDING THE WARRANTIES OF MERCHANTABILITY AND FITNESS FOR A PARTICULAR PURPOSE, ALL OF WHICH ARE HEREBY EXCLUDED.**

**9. UNDER NO CIRCUMSTANCES SHALL EITHER PARTY BE LIABLE TO THE OTHER PARTY FOR CLAIMS FOR LOSS OF DATA, GOODWILL, PROFITS, USE OF MONEY, INTERRUPTION IN USE OR AVAILABILITY OF DATA, STOPPAGE OF SERVICE, OR OTHER WORK OR IMPAIRMENT OF OTHER ASSETS OR FOR LOSS WHICH IS CONSEQUENTIAL, INDIRECT, SPECIAL, PUNITIVE, OR INCIDENTAL, WHETHER FORESEEABLE OR UNFORESEEABLE BASED ON CLAIMS OF THE OTHER PARTY ARISING OUT OF BREACH OR FAILURE OF EXPRESS OR IMPLIED WARRANTY, BREACH OF CONTRACT, MISREPRESENTATION, NEGLIGENCE, STRICT LIABILITY IN TORT OR OTHERWISE. IN THE EVENT THAT A PARTY FAILS TO SEND OR RECEIVE A TRANSACTION IN ACCORDANCE WITH THE TERMS OF THIS AGREEMENT, SUCH PARTY SHALL USE COMMERCIALY REASONABLE EFFORTS TO CORRECT SUCH FAILURE PROMPTLY, WHICH SHALL BE THE OTHER PARTY'S SOLE AND EXCLUSIVE REMEDY FOR SUCH FAILURE.**

10. The term of this Agreement shall become effective on the \_\_\_\_ day of \_\_\_\_, 2008 ("Effective Date") and shall continue thereafter for twelve (12) consecutive months, such total time designated as the initial term. Thereafter, this Agreement shall automatically renew for successive twelve (12) month terms unless either party gives the other written notice of non-renewal not less than ninety (90) days prior to the end of the then current term. If either party fails to observe or perform any material obligation under this Agreement, then following the parties' good faith efforts to resolve the dispute, the non-defaulting party may give written notice to the defaulting party specifying the material failure. If the material failure is not corrected or a mutually agreed upon plan to correct the failure has not been established within sixty (60) days after the date of such notice, the non-defaulting party may terminate this Agreement upon written notice to the defaulting party. In the event that the provisions of HIPAA and regulations promulgated there under require a change in the responsibilities of either party and the parties are unable to agree on conforming changes to this Agreement, then either party may terminate this Agreement by giving 30 days written notice to the other party. Upon expiration or termination of this Agreement for any reason, the parties shall promptly determine a transition strategy in order to minimize the impact of moving to an alternative service solution for the affected Providers.

11. Neither party shall make any promises, commitments, representations or warranties to a Provider about the other party or its products or services without the express prior written approval of that other party. The relationship of the parties is that of independent contractors. Each party hereby acknowledges that it has no power or authority to act on behalf of the other party as its agent, and that its authority is limited in

accordance with the terms and conditions of this Agreement. Nothing in this Agreement shall be construed to make the parties hereto partners, joint ventures, or agents of or with each other, nor shall either party so represent itself. The parties shall mutually agree in writing upon any communications or releases relating to this Agreement, as well as to any usage of the other party's name, trademark, logo, copyright or other proprietary or commercial right, provided, however, that either party may market its respective services to Providers and prospective customers without limitation and, subject to the terms of this Agreement, may disclose to them the services of the other party.

12. Sections 7, 8, 9 and 13 shall survive termination of this Agreement. This Agreement shall not be assigned by either party without the prior written consent of the other, except, with written notice to the other party, to an affiliate or to a successor by purchase, merger, or consolidation. No assignment shall relieve the assignor of its obligations under this Agreement. This Agreement shall be governed by the laws of Pennsylvania, without regard to its principles of conflicts of law. Each party shall bear its own expense of performing under this Agreement.

13. This Agreement constitutes the entire agreement between Submitter and THE HEALTH PLAN, and supersedes all other prior and contemporaneous agreements, understandings, and commitments between them, relating to the subject matter hereof. The invalidity of any provision of this Agreement shall not affect the validity of the remaining provisions, and this Agreement shall be construed as if such invalid provision had been omitted. No provision of this Agreement may be terminated, modified, or waived except as set forth in a written agreement executed by authorized representatives of the parties.

14. Neither party will pay fees or other compensation to the other party for the

performance of their respective obligations hereunder.

AGREED:

Submitter

The Health Plan of the Upper Ohio Valley

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

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

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

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

# EXHIBIT A

Provider Name(s):

Transactions: 837 VERSION 4010 Institutional and Professional  
835 version 4010

# Trading Partner Profile

(Please Print)

In order to expedite the set up process, please fill out the following fields completely.  
Once complete, please e-mail this form to [roses@healthplan.org](mailto:roses@healthplan.org).

GENERAL INFORMATION			
Trading Partner Name:			
Street address:			
City:	State:	ZIP Code:	
Main Telephone Number: ( )	Main Fax Number: ( )		
Website URL:			
Companion Guide Location:			
Trading Partner Type:	<input type="checkbox"/> Medicare	<input type="checkbox"/> Medicaid	<input type="checkbox"/> Commercial

TESTING CONTACT INFORMATION	
This will be our main contact for testing information and results.	
Testing Contact Name: Rose Sarcopski	Title: EDI Support Center
Telephone: (800) 624-6961 Ext 6189 or 740-699-6189	Fax: (740) 695-5297
E-Mail:	roses@healthplan.org

OPERATIONS CONTACT INFORMATION	
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### ENROLLMENT CONTACT INFORMATION

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Enrollment Contact Name:		Title:	
Street address:			
City:		State:	ZIP Code:
Telephone: (    )		Fax: (    )	
E-Mail:			

### EDI ENVELOPING INFORMATION

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Interchange Sender ID (ISA06):	
Interchange ID Qualifier (ISA07):	ZZ
Interchange Receiver ID (ISA08):	Healthplan
Application Sender's Code (GS02):	
Application Receiver's Code (GS03):	Healthplan
Submitter ID (NM1*41, 1000A loop):	
Receiver Name (NM1*40, 1000B loop):	
Receiver ID (NM1*40, 1000B loop):	
Payer Identifier (NM1*PR, 2010BB loop):	
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Maximum number of claims per production file:	10,000 per HIPAA

**DELIMITER INFORMATION**

Utilize the grid below to indicate the delimiters you require for inbound transactions.

Segment Terminator:	
Element Separator:	
Sub-Element Separator:	

**TESTING REQUIREMENTS**

Utilize the grid below to outline your inbound testing requirements.

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Actual Go-Live Date <i>(Internal Use Only)</i>	

**ADDITIONAL INFORMATION**

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