



QHA

Quantum Health Automation

Welcome to the QHA Network!

Your decision to submit electronic transactions is a sound choice which will reduce healthcare costs, while accelerating your claim payments.

Our goal is to make your entire electronic filing experience as enjoyable as possible. Here is a brief overview of steps that need to be taken to begin electronic filing with QHA.

PERTINENT INFORMATION

Before QHA can process your information electronically, please perform the following:

- 1) Fill out the Provider Information Sheet for each practicing physician.
- 2) Have each physician sign the Customer Authorization Sheet.
- 3) Please sign the Closing Document "Electronic Claims & Transaction Service Agreement" for EDI (Electronic Data Interchange) submission.
- 4) Sign and Date the BAA (HIPAA Business Associate Agreement)

NOTE: PLEASE MAKE A COPY OF THE BUSINESS ASSOCIATE AGREEMENT FOR YOUR HIPAA MANUAL. PLEASE MAKE COPIES OF THE CUSTOMER AUTHORIZATION FORM AND PROVIDER INFORMATION SHEETS FOR ADDITIONAL PROVIDERS NOW AND IN THE FUTURE. WE WILL ONLY NEED ONE ELECTRONIC CLAIMS AND TRANSACTION SERVICE AGREEMENT PER FED ID/SOC SECURITY NUMBER YOU WILL BE FILING IN BOX 25 OF THE HCFA FORM.

Return these sheets to our company as soon as possible to prevent delays in the handling of your data. Please make sure it is filled out entirely.

If the information is faxed, please submit to:

#1-812-759-1524 FAX LINE
ATTENTION: ROBYN PAGE
QHA EDI SERVICES

OR Mail original of the "Electronic Claims & Transactions Service Agreement" to:

QHA EDI SERVICES
201 NW FOURTH STREET
SUITE # 103
EVANSVILLE, IN 47708-1356

Once we have received your information, please allow two to six weeks for your Medicare, Medicaid, and BCBS claims to be filed electronically. If State Payer claims are sent to QHA prior to APPROVAL, these claims may be sent on paper until carriers are approved. Commercial or private insurance are pre-approved for electronic filing.

Provider NAME: _____

BILLING COMPANY: _____

HCFA Box 33 Name/PAY TO: _____

Physical Office Name: _____

Box 33 Address: _____

Physical Address: _____

Box 33 City/State/Zip: _____

Physical City/State/Zip: _____

County: _____ Contact: _____ Fax #: () - _____ - _____

Office Specialty: _____ Speciality Code: _____

Contact E-mail: _____

Software Name and Vendor: _____

Taxonomy code(s): _____

PROVIDER IDENTIFICATION NUMBERS: *** Tax ID (must be 9 digits): _____ (or Soc Security #)

The LIST below are the MAIN carriers of concern. ***** It is your responsibility to report any provider number ADDITIONS or REVISIONS to QHA *****

Please ensure that the information indicated below is ACCURATE and LEGIBLE. Clarify Z's and 0's with a slash mark so they are not read incorrectly as 2's or O's.

<u>Individual provider numbers</u>	<u>Group or Facility provider numbers</u>	<u>State</u>
Medicare _____	_____	_____
Medicaid _____	_____	_____
Blue Cross/Blue Shield _____	_____	_____
RR Medicare _____	_____	_____
Medical Mutual of OHIO _____	_____	_____
Tricare _____	_____	_____
DMERC A B C or D?: _____ (pls circle region)	_____	_____
Other payer: _____	_____	_____
State License #: _____	UPIN: _____	Premiera: _____ Regence (WA / OR): _____

Individual (Type1) NPI: _____ **Group (Type 2) NPI:** _____

*** note - national provider identifier is REQUIRED ***

PLEASE CIRCLE ONE OF FOLLOWING: NEW CLIENT or EXISTING (if existing, CLIENT ID: _____)

Completed by: _____ Date: _____ / _____ / 20 _____

Other information: _____



1-800-500-8747
qhaclaims.com

Customer Authorization

Agreement:

I, _____, by my signature affixed hereto, empower, direct, and authorize Quantum Health Automation, Inc. to execute, print, copy, duplicate or otherwise affix my signature to the following medical forms:

1. HCFA-1500 Medical Forms
2. UB-92 Medical Forms
3. Dental Forms
4. Agreements for Submission and Reception of Electronic Healthcare Transactions such as claims and remittance advise.

I have provided QHA with all provider numbers for Group and Individual Identification Numbers, Tax Id Number, Social Security Number, to be used as needed in the forms stated above. I will further acknowledge that QHA will be relying on the accuracy of that information.

I DO NOT authorize QHA to use my provider numbers for identification in cases not required by the Payer.

The purpose of this document is to authorize QHA for service stated and no other reason. Any attempt to otherwise duplicate said signature will be of no force or effect.

The parties to this agreement agree that this agreement may be executed simultaneously or in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The parties agree that this agreement may be transmitted between them by facsimile machine and electronic mail. The parties intend that faxed signatures constitute original signatures and are binding on the parties. The original document shall be promptly executed and/or delivered, if requested.

Authorized Signature

_____/_____/_____

Title

Date

Please STAMP your practice name & address.

- **Please mail this form to:**
Quantum Health Automation, Inc.
201 N.W. 4th Street, Suite 103
Evansville, IN 47708
Attn: New Accounts Dept.

-or-

- **Fax this form to:**
1-812-468-8478
Attn: New Accounts Dept.

**Thank you for your cooperation,
Quantum Health Automation, Inc.**

BUSINESS ASSOCIATE AGREEMENT

Effective Date: _____

“Customer” or “Covered Entity”:

Name: _____
Address: _____
City: _____ State: _____ Zip: _____
Fax: _____
Attention: _____

“Business Associate”:

Name: Quantum Health Automation, Inc., an Indiana corporation
Address: 201 NW Fourth Street, Ste 103
Evansville, IN 47708-1356
Fax: (812) 468-8478
Attention: HIPAA CONTRACT ADMINISTRATOR

This Agreement is entered into by and between Customer and Business Associate (each a “Party” and collectively the “Parties”) to set forth the terms and conditions under which “protected health information”, as defined by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Regulations enacted thereunder, created or received by “Business Associate” on behalf of Customer may be used or disclosed.

This Agreement shall commence on the “Effective Date” – or, if no date is entered, the date this document is signed by Business Associate - and the obligations herein shall continue in effect so long as Business Associate uses, discloses, creates or otherwise possesses any protected health information created or received on behalf of Customer and until all protected health information created or received by Business Associate on behalf of Customer is destroyed or returned to Customer pursuant to Paragraph 15 herein.

Definitions:

Privacy Rule. “Privacy Rule” shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR Part 160 and Part 164, Subparts A and E (of the HIPAA regulations).

Protected Health Information. “Protected Health Information: shall have the same meaning as the term “protected health information” in 45 CFR & 164.501 (of the HIPAA regulations), limited to the information created or received by Business Associate from or on behalf of Covered Entity.

Required By Law. “Required By Law” shall have the same meaning as the term “required by law” in 45 CFR & 164.501 (of the HIPAA regulations).

1) Customer and Business Associate hereby agree that Business Associate shall be permitted to use and/or disclose protected health information created or received on behalf of Customer for the following purpose(s):

- (i) Health care claims or equivalent encounter information.
- (ii) Health care payment and remittance advice.
- (iii) Health care claim status.
- (iv) Eligibility for a health plan.
- (v) Health plan premium payments.
- (vi) Referral certification and authorization.
- (vii) Health claims attachments.
- (viii) Other transactions that the Secretary may prescribe by regulation.

1.1 Moreover, Business Associate may disclose Protected Health Information for the purposes authorized by this Agreement including, but not limited to, Section 1.2 below and Section 5 and 6 of this Agreement below.

- (i) to its employees; and
- (ii) subcontractors and agents
- (iii) as directed by the Customer

1.2 Business Associate may use and disclose Protected Health Information for the proper management and administration of the Business Associate, as provided in Business Associate’s then said Electronic Claims and Transaction Service Agreement; and to provide data aggregation/analysis services relating to the health care operations of the Customer.

2.) Business Associate may use and disclose protected health information created or received by Business Associate on behalf of Customer if necessary for the proper management and administration of Business Associate or to carry out Business Associate’s legal responsibilities, provided that any disclosure is:

- a) Required by law, or

- b) Business Associate obtains reasonable assurances from the person to whom the protected health information is disclosed that (i) the protected health information will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person; and (ii) the Business Associate will be notified of any instances of which the person is aware in which the confidentiality of the information is breached.
- 3.) Business Associate hereby agrees to maintain the security and privacy of all protected health information in a manner consistent with Indiana and federal laws and regulations, including the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and Regulations thereunder, and all other applicable law.
- 4.) Business Associate further agrees not to use or disclose protected health information except as expressly permitted by this Agreement, applicable law, or for the purpose of managing Business Associate's own internal business processes consistent with Paragraph 2 herein.
- 5.) Business Associate shall not disclose protected health information to any member of its workforce unless Business Associate has advised such person of Business Associate's privacy and security obligations under this Agreement, including the consequences for violation of such obligations. Business Associate shall take appropriate disciplinary action against any member of its workforce who uses or discloses protected health information in violations of this Agreement and applicable law.
- 6.) Business Associate shall not disclose protected health information created or received by Business Associate on behalf of Customer to a person, including any agent or subcontractor of Business Associate but not including a member of Business Associate's own workforce, until such person agrees in writing to be bound by the provisions of this Agreement and applicable Indiana or Federal law.
- 7.) Business Associate agrees to use appropriate safeguards to prevent use or disclosure of protected health information not permitted by this Agreement or applicable law.
- 8.) Business Associate agrees to maintain a record of all disclosures of protected health information, including disclosures not made for the purposes of this Agreement. Such record shall include the date of the disclosure, the name and, if known, the address of the recipient of the protected health information, the name of the individual who is the subject of the protected health information, a brief description of the protected health information disclosed, and the purpose of the disclosure. Business Associate shall make such record available to an individual who is the subject of such information or Customer within ten (10) days of a request and shall include disclosures made on or after the date which is six (6) years prior to the request or April 14, 2003, whichever is later.
- 9.) Business Associate agrees to report to Customer any unauthorized use or disclosure of protected health information by Business Associate or its workforce or subcontractors and the remedial action taken or proposed to be taken with respect to such use or disclosure.
- 10.) Business Associate agrees to make its internal practices, books, and records relating to the use and disclosure of protected health information received from Customer, or created or received by Business Associate on behalf of Customer, available to the Secretary of the United States Department of Health and Human Services, for purposes of determining the Covered Entity's compliance with HIPAA.
- 11.) Within thirty (30) days of a written request by Customer, Business Associate shall allow a person who is the subject of protected health information, such person's legal representative, or Customer to have access to and to copy such person's protected health information maintained by Business Associate. Business Associate shall provide protected health information in a feasible format requested by such person, legal representative, or practitioner unless it is not readily producible in such format, in which case it shall be produced in standard hard copy format.
- 12.) Business Associate and Customer agrees to amend, pursuant to a request by Customer or Business Associate, protected health information maintained and created or received by Business Associate on behalf of Customer. Business Associate further agrees to complete such amendment within thirty (30) days of a written request by Customer, and to make such amendment as directed by Customer.
- 13.) In the event Business Associate or Customer fails to perform the obligations under this Agreement, Customer or Business Associate may, at its option:
- a) Require Business Associate or Customer to submit to a plan of compliance, including monitoring by Customer or Business Associate and reporting by Business Associate or Customer, as Customer or Business Associate, in its sole discretion, determines necessary to maintain compliance with this Agreement and applicable law. Such plan shall be incorporated into this Agreement by amendment hereto; and
 - b) Business Associate agrees to mitigate, to the extent reasonably practicable, any harmful effect, that is known to Business Associate, of a use or disclosure of PHI by Business Associate in violation of this Agreement.
 - c) Immediately discontinue providing protected health information to Business Associate with or without written notice to Business Associate.

14.) Customer or Business Associate may immediately terminate this Agreement and related agreements if Customer or Business Associate determines that the Business Associate or Customer has breached a material term of this Agreement. Alternatively, Customer or Business Associate may choose to: (i) provide Business Associate or Customer with ten (10) days written notice of the existence of an alleged material breach; and (ii) afford the Business Associate or Customer an opportunity to cure said alleged material breach to the satisfaction of Customer or Business Associate within ten (10) days. The Business Associate's or Customer's failure to cure shall be grounds for immediate determination of this Agreement. Customer's and Business Associate's remedies under this Agreement are cumulative, and the exercise of any remedy shall not preclude the exercise of any other.

15.) Upon termination of this Agreement, Business Associate shall return or destroy all protected health information received from Customer, or created or received by Business Associate on behalf of Customer and that Business Associate maintains in any form, and shall retain no copies of such information. If the parties mutually agree that return or destruction of protected health information is not feasible, Business Associate shall continue to maintain the security and privacy of such protected health information in a manner consistent with the obligations of this Agreement and as required by applicable law, and shall limit further use of the information to those purposes that make the return or destruction of the information infeasible. The duties hereunder to maintain the security and privacy of protected health information shall survive the discontinuance of this Agreement.

16.) Customer or Business Associate may amend this Agreement by providing ten (10) days prior written notice to Business Associate or Customer in order to maintain compliance with Indiana or Federal law. Such amendment shall be binding upon Business Associate or Customer at the end of the ten (10) day period and shall not require the consent of Business Associate or Customer. Business Associate may elect to discontinue the Agreement within the ten (10) day period, but Business Associate's duties hereunder to maintain the security and privacy of PROTECTED HEALTH INFORMATION shall survive such discontinuance. Customer and Business Associate may otherwise amend this Agreement by mutual written agreement.

17.) Force Majeure. Neither party shall be liable to the other party for any interruption or delay in fulfilling the party's obligations under this Agreement if such interruption or delay arises solely from causes beyond such party's reasonable control, including without limitation, acts of God, acts of any government, war or other hostility, civil disorder, the elements, fire, explosion, power failure, telecommunications service failure or interruption, equipment failure, industrial or labor dispute, or inability to access necessary supplies.

18.) The parties of this Agreement agree that this agreement may be executed simultaneously or in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The parties agree that this agreement may be transmitted between them by facsimile machine and electronic mail. The parties intend that faxed signatures constitute original signatures and are binding on the parties. The original document shall be promptly executed and/or delivered, if requested.

19.) If any controversy, dispute or claim arises between the Parties with respect to this Agreement, each Party shall make good faith efforts to resolve such matters informally.

20.) Business Associate is responsible for its own compliance. Customer is responsible for its own HIPAA Compliance.

21.) Notices, changes in address or contact information shall be made via U.S. Mail, express couriers, facsimile to each parties information listed above on this Agreement.

22.) The parties acknowledge that their obligations hereunder may be subject to regulation under federal, state and local laws. Each party agrees that it will at all times conform its actions to all applicable legal requirements and will, to the extent commercially reasonable, assist the other in compliance with such requirements. Each party acknowledges that it has read this Agreement, understands it, and agrees to be bound by its terms and further agrees that it is the complete and exclusive statement of the Agreement between the parties, which supersedes and merges all prior proposals, understandings and all other commercial claims agreements, oral and written, between the parties relating to this Agreement. This Agreement and performance hereunder shall be governed by and construed in accordance with the internal laws of the State of Indiana. If any provision of this Agreement shall be held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall in no way be affected or impaired thereby. The waiver of failure of either party to exercise in any respect any right provided for herein shall not be deemed a waiver or any further right hereunder.

IN WITNESS WHEREOF, the undersigned have duly executed THIS AGREEMENT as of the date first above written as Effective Date.

CUSTOMER

QUANTUM HEALTH AUTOMATION, INC.

By: _____

By: _____

Name: _____

Name: _____

Title: _____

Title: _____

Date: _____

Date: _____

Quantum Health Automation, Inc.

Electronic Claims & Transaction Service Agreement

THIS AGREEMENT made and entered into in Evansville, Indiana, this _____ day of _____, 20____, by and between Quantum Health Automation, Inc., (hereinafter referred to as "QHA"), an Indiana Corporation, and _____ of _____, (hereinafter referred to as "Customer"), specifies the terms upon which QHA will submit claims and transactions to commercial and claims clearinghouses (hereinafter called "Payers") for services or supplies rendered or provided by the health service providers (hereinafter called "Providers") that are connected, owned or established by in any way by "Customer".

Witnesseth:

In consideration of the mutual promises herein, QHA and the Customer agrees as follows:

1. Services. QHA shall, in accordance with its then current procedures, submit on behalf of The Customer's provider base, electronic or paper claims (as designated by Providers) to Payers. QHA shall use all commercially reasonable means to ensure the prompt and accurate submission of claims and electronic transactions in accordance with the requirements of Payers and the United States Postal Service. QHA shall acknowledge receipt of the Customer's providers' transmission of claims and electronic services by making available regular "Edit Reports" to the Customer.
2. Responsibilities of Parties. Providers shall be solely responsible for ensuring the accuracy and adequacy of all claim information and for the accurate transmission of claim, statement and transaction information to QHA. The Customer and Providers agree to hold harmless QHA against all liability or costs (including attorney fees) pertaining to errors and omissions mentioned above and below of this paragraph 2. Providers shall submit information to QHA in the manner and format required by QHA, and Provider shall be solely responsible for any delay, loss, or damage to information in the course of transmission to QHA. Provider agrees to comply with all Payer contractual and legal requirements relating to the submission of claims. The Customer and Providers shall indemnify and hold harmless QHA against all liability or costs (including attorney fees) incurred as a result of breach of this paragraph 2.
3. Fees. For its services under this Agreement, QHA shall receive a monthly fee to be determined in accordance with QHA's then current fee schedule listed in the attached Exhibit A of this Agreement. QHA reserves the right to change its fee schedule upon thirty (30) days prior written notice to the Customer and Providers. All fees shall be due and payable in full in accordance with terms on the invoice. Finance charges will be applied to the past due charges and shall be due and payable in full in accordance with the terms of the invoice.

Quantum Health Automation, Inc.

4. Term. The term of this Agreement shall commence upon the effective date written above and continue until terminated. This Agreement may be terminated:

- (a) by either party upon 30 days prior written notice to the other, or
- (b) by QHA upon 5 days notice to Provider in the event Provider or Customer fails to make when due any payment required by this Agreement; or
- (c) by QHA without notice in the event Provider is in breach of its of its responsibilities under Paragraph 2 or 3 above.

5. Disclaimer of Responsibility. QHA shall have no responsibility for any claim until receipt of claim is acknowledged as an accepted claim by QHA through inclusion in an Edit Report. QHA shall not be liable for any failure caused by circumstances beyond the control of QHA, including, without limitation, situations of national emergency, fire, flood, other catastrophes and acts of God, insurrection, war, riots, failures of transportation, interruptions of communications or power supplies, or mechanical difficulties with the computer equipment of QHA not reasonably anticipatable or preventable. QHA shall have no responsibility for any acts of Payers.

6. Confidentiality. QHA shall to the extent required by law treat as confidential all claims information received from Provider and the Customer.

7. General. The parties acknowledge that their obligations hereunder may be subject to regulation under federal, state, and local laws. Each party agrees that it will at all times conform its actions to all applicable legal requirements and will, to the extent commercially reasonable, assist the other in compliance with such requirements. Each party acknowledges that it has read this Agreement, understands it, and agrees to be bound by its terms and further agrees that it is the complete and exclusive statement of the Agreement between the parties, which supersedes and merges all prior proposals, understandings and all other claim agreements, oral and written, between the parties relating to this Agreement. This Agreement and performance hereunder shall be governed by and construed in accordance with the internal laws of the State of Indiana. If any provision of this Agreement shall be held to be invalid, illegal or unenforceable, the validity, legality and enforceability of the remaining provisions shall in no way be affected or impaired thereby. The waiver of failure of either party to exercise in any respect any right provided for herein shall not be deemed a waiver or any further right hereunder. QHA may assign its rights and responsibilities under this Agreement to its subsidiaries or affiliates by giving 60 days prior written notice to the Provider.

The parties to this agreement agree that this agreement may be executed simultaneously or in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument. The parties agree that this agreement may be transmitted between them by facsimile machine and electronic mail. The parties intend that faxed signatures constitute original signatures and are binding on the parties. The original document shall be promptly executed and/or delivered, if requested.

This agreement shall not be effective until signed by a Quantum Health Automation's representative.

QHA: _____

Provider: _____

Title: _____

Title: _____

Date: _____

Date: _____

Exhibit A
PROVIDER INVESTMENT

I.	ANNUAL SERVICE FEE	PROVIDER
	A. FIRST YEAR	\$00.00
	B. SUBSEQUENT YEARS	\$00.00
II.	APPLICATION FEE	
	A. ESTABLISH CONNECTION AND MAPPING	\$00.00
III.	PER TRANSACTIONS	
	A. BATCH TRANSACTIONS – FLAT RATE	
	1. CLAIMS	
	A. COMMERCIAL	
	B. STATE PAYERS (Medicare, Medicaid, Blue Shield)	\$59.95 per month per provider
	C. PRINT & MAIL	\$.45

MINIMUM REQUIREMENT FEE:

**IF PROVIDER IS SENDING LESS THAN \$10.00 A MONTH OF
*QUALIFYING CLAIMS, AN AUTOMATIC CHARGE OF \$10.00 WILL BE ASSESSED. THIS FEE WILL
NOT BE ADDED TO THE CLAIMS PER TRANSACTION FEE SENT DURING ANY PARTICULAR MONTH.
THE PROVIDER’S CHARGE FOR ANY PARTICULAR MONTH WILL THEN BE ONLY THE \$10.00**

***QUALIFYING CLAIMS ARE ALL CLAIMS SUBMITTED DURING ANY PARTICULAR MONTH.**

- VII. SYSTEM SUPPORT**
- **YEARLY UPGRADES AND REVISIONS OF THE BULLETING BOARD SERVICES (BBS).**
 - **TOLL FREE CLAIM SUBMISSION LINE FOR LONG DISTANCE CALLERS.**
 - **TOLL FREE CUSTOMER SUPPORT LINE FOR CLAIM QUESTIONS.**

- VIII. NOTES**
- **QHA RESERVES THE RIGHT TO CORRECT ANY MISTAKES MADE IN THE PREPARATION OF THIS CONTRACT.**
 - **THIS CONTRACT DOES NOT INCLUDE APPLICABLE SALES TAX OR FREIGHT ON ITEMS SUBJECT TO SUCH.**
 - **ALL PRICES ARE SUBJECT TO CHANGE UPON THIRTY (30) DAYS WRITTEN NOTICE BY EITHER PARTY.**

**By signing below, the parties agree to all of the terms and conditions set forth above.
This contract is not valid until signed by an authorized QHA representative.**

Provider

Quantum Health Automation

Name: _____
Signature: _____
Title: _____
Date: _____

Name: _____
Signature: _____
Title: _____
Date: _____