

Security Packet B
AGREEMENT for eMedNY System ACCESS
Instructions for Completion

1. Please read the Agreement. Your signature indicates acceptance to the terms and conditions of this Agreement.
2. Complete the information requested at the bottom of the Agreement form and sign the Agreement. Please print or type the following information:
 - a) ***Provider Number (All providers and vendors are required to enroll in the Medicaid Program)***
Enter your eight-digit Medicaid Provider ID Number, which was assigned by the Department of Health at the time of your enrollment in the Medicaid Program.
 - b) ***Provider/Vendor Name***
Enter the name of the Provider/Vendor that will be subject to the agreement. (Enter the name associated with the Provider ID Number entered above).
 - c) ***Street Address, City, State, Zip***
Enter the address where you would like to receive correspondence from CSC. Please note that it must be a **Street Address, not a P.O. Box.**
 - d) ***By***
Print the name of the authorized person who signs the Agreement.
 - e) ***Title***
Print the title of the authorized person who signs the Agreement.
 - f) ***Date***
Enter the date on which the Agreement is signed.
3. Mail the completed form to:

Computer Sciences Corporation
Attn: Provider Enrollment Support
P.O. Box 4614
Rensselaer, NY 12144

AGREEMENT for eMedNY System ACCESS

WHEREAS, the New York State Department of Health (the "Department") and Computer Sciences Corporation ("CSC"), have entered into an agreement whereby CSC provides direct electronic access to MEDICAID eligibility verification, claims submission, and other electronic transactions, for Medical Providers/Vendors and their agents (Provider/Vendor) to the eMedNY System; and

WHEREAS, Provider/Vendor performs certain medical services and/or provides medical supplies for recipients who are eligible for MEDICAID benefits, or performs data processing services for such entities; and

WHEREAS, Provider/Vendor has requested direct electronic access to the eMedNY System;

NOW, THEREFORE, CSC and Provider/Vendor agree as follows:

1. CSC-eMedNY will supply to Provider/Vendor the technical specifications required to establish the link to the eMedNY System (Exhibit A). Provider/Vendor is responsible for all costs associated with complying with such requirements.
2. Provider/Vendor agrees to comply with the system requirements and any additional terms set forth on Exhibit A.
3. After Provider/Vendor has obtained initial access to the eMedNY System, Provider/Vendor agrees to re-test its link to the System in the event:
 - Provider's/Vendor's link is changed or modified in any way, or
 - The technical specifications change in response to Department mandated program changes
 - Provider/Vendor agrees to follow CSC's then current procedures for obtaining such access.
4. Provider/Vendor agrees to pay any hosting charges for any equipment above and beyond the standard interface equipment specified by CSC, including installation, provisioning and utility charges. These charges may be paid in a single one-time charge depending upon the configurations of equipment requested.
5. Provider/Vendor is expected to manage provisioning and management of their respective connections to eMedNY.
6. Provider/Vendor agrees to pay any damages that are caused by, result from, or are in any way attributable to Provider/Vendor, its employees', agents' and independent contractors' negligent use of the eMedNY System, fraud or intentional misconduct or Provider's/Vendors' failure to certify or re-certify its link to the eMedNY System.
7. Provider/Vendor agrees to exercise due diligence in protecting Provider/Vendor systems so that malicious software is not introduced to eMedNY Systems.
8. Provider/Vendor accepts and agrees to comply with the Provisions of this eMedNY Security Agreement.
9. This Agreement shall become effective upon approval by CSC-eMedNY, on behalf of the New York State Department of Health and shall continue thereafter until terminated by either party on 60 days notice in writing.

Provider Number By: _____
Please print name

Provider/Vendor Name Signature

Street Address Title: _____

City, State, Zip Date: _____

AGREEMENT for eMedNY System ACCESS
****EXHIBIT A****

SYSTEM REQUIREMENTS

Batch PC-to-Host (Dial-up FTP):

- Point-to-Point Protocol (PPP)
- TCP/IP Protocol with File Transfer Protocol (FTP)
- Compliance with HIPAA File Format
- eMedNY Electronic Gateway

OTHER TERMS

1. Provider/Vendor shall order the telecommunication lines and equipment necessary to link Provider's/Vendor's system to the eMedNY System. Provider/Vendor will be responsible for monitoring, diagnosing and establishing dial backup on the telecommunication lines and equipment.
2. CSC does not provide consultation services beyond simple installation troubleshooting. For example, we cannot assist with the installation of the operating system or configuration issues involving the Provider's/Vendor's LAN, PC, modem or printer. CSC does not support Provider/Vendor hardware or software.
3. For qualified Providers/Vendors, CSC will provide support for the ePACES, and other electronic transaction software supplied by CSC, so long as CSC is the State of New York eMedNY contractor and Provider/Vendor has not altered or modified the software in any way.

PROVIDER/VENDOR eMedNY Access Request Form
Instructions for Completion

Please type or print all required information.

1. User Information (*User is the Provider enrolled in the New York State Medical Assistance Program [Medicaid] or the Vendor that supplies switch services to a group of providers*)

Name

- If you are an individual Provider, enter your last name, first name, and middle initial (if any)
- If the Medicaid Provider ID number applies to a business (i.e. Pharmacy, DME Supplier, Laboratory, etc.), enter the name of the individual authorized to sign the eMedNY Access Request on behalf of the provider organization.
- If you are a Vendor, enter the Company name.

Address

Enter the address where you would like to receive correspondence from CSC.

Indicate

Check the box (only one box please) that best indicate your user status. If you check the box next to **Other**, please explain.

Medicaid Provider ID (all providers and vendors are required to enroll in the Medicaid Program).

Enter your (or your organization's) eight-digit Medicaid Provider ID Number, which was assigned by the Department of Health at the time of enrollment in the Medicaid Program.

Phone Number

Enter the phone number at which you can be contacted.

2. Alternate Access Required

Check the platform(s) through which you will be accessing eMedNY.

3. Requestor Information

Requestor's Name

Enter the name of the authorized person requesting access to eMedNY.

Date

Enter the date on which the request was completed.

Phone Number

Enter the phone number at which CSC can contact you if necessary.

LEAVE SECTIONS 4 AND 5 BLANK. THESE ARE FOR CSC USE ONLY.

PROVIDER/VENDOR eMedNY Access Request Form

◆ 1. User Information				
USER INFORMATION	Last Name:	First Name:	Middle Initial:	
	Position/Title:		Phone Number:	
	Address:			
INDICATE: <input type="checkbox"/> Medical Provider <input type="checkbox"/> Service Bureau <input type="checkbox"/> Connectivity Switch Provider/Vendor <input type="checkbox"/> Other _____		MEDICAID PROVIDER ID:		
◆ 2. Alternate Access Required (Please see exhibit A for minimum requirements)				
PLATFORM	You <u>must</u> check applicable platform(s).			
	<input type="checkbox"/> FTP batch submission (Dial-up)			
	<input type="checkbox"/> NCPDP batch-submission (Dial-up)			
	<input type="checkbox"/> eMedNY Electronic Gateway (Dial-up)			
◆ 3. Requestor Information				
Requestor's Name:		Date:	Phone Number:	
◆ 4. Approvals (For CSC eMedNY Use Only)				
APPR 1	Approver's Name:	Signature:	Date:	Phone number:
APPR 2	Approver's Name:	Signature:	Date:	Phone number:
◆ 5. Administration (For CSC eMedNY Data Security Use Only)				
DATA SECURITY	Type of User ID assigned:			
	Comments:			
	Administrator Name:		Administrator Signature:	
	Date:			
			New USERID	Initial password

**SECURITY AGREEMENT FOR
NEW YORK STATE-eMedNY SYSTEM
Instructions for Completion**

1. Please read the **USERID AND PASSWORD RULES**. By signing the Agreement, you indicate acceptance to the terms and conditions of this Agreement.

2. Complete the information requested at the bottom of the Agreement form and sign the Agreement. Please type or print the following information:
 - a) ***Provider Number (all providers and vendors are required to enroll in the Medicaid Program)***
Enter your eight-digit Medicaid Provider ID Number, which was assigned by the Department of Health at the time of your enrollment in the Medicaid Program.

 - b) ***Provider/Vendor Name***
Enter the name of the Provider/Vendor that will be subject to the agreement. (If you have a Medicaid Provider ID, enter the name associated with the Provider ID Number entered above).

 - c) ***Street Address, City, State, Zip***
Enter the address where you would like to receive correspondence from CSC. Please note that it must be a **Street Address, not a P.O. Box.**

 - d) ***By***
Print the name of the authorized person who signs the Agreement.

 - e) ***Title***
Print the title of the authorized person who signs the Agreement.

 - f) ***Date***
Enter the date on which the Agreement is signed.

**SECURITY AGREEMENT
NEW YORK STATE-eMedNY SYSTEM**

All users of Medicaid data and systems are required to affirm their understanding and agreement to comply with the following USERID and Password rules before access can be granted.

USERID AND PASSWORD RULES

A USERID and password will be provided by CSC-eMedNY Data Security upon approval of this security agreement. CSC, in accordance with the Federal Information Processing Standards and the Privacy Act of 1974, requires that all users of the system be aware of and comply with the following rules regarding USERIDS and Passwords:

- a) USERIDS and Passwords must not be shared with anyone. A USERID is assigned by CSC-eMedNY Data Security solely to an individual and the individual is responsible for all system activity related to that USERID.
- b) After four consecutive password violations (i.e., entering the wrong password) the USERID is revoked. If this occurs, CSC-eMedNY Data Security Administration intervention is required to reactivate the USERID. Contact Provider Relations to activate this intervention.

I have read and fully understand the USERID and Password rules as set out above.

🔔🔔🔔🔔🔔IMPORTANT ** PLEASE READ ** IMPORTANT🔔🔔🔔🔔🔔

On the line below, you MUST provide a Unique Identifier that will be used to identify this Provider/Vendor when corresponding via telephone. The Unique Identifier should be something only this Provider/Vendor knows, (i.e. mother's maiden name, pet's name, etc.), and will be used to verify the identity of the person to whom we are providing sensitive information such as account User IDs and passwords.

UNIQUE IDENTIFIER: _____

Provider Number By: _____
Please Print Name

Provider/Vendor Name Signature

Street Address Title: _____

City, State, Zip Date: _____