835 ELECTRONIC REMITTANCE ADVICE AGREEMENT
TO RECEIVE X12 835 ELECTRONIC TRANSACTIONS

This is to certify that ____of
(Name of Pharmacy location submitting healthcare claims **and NPI Number**)

____ _________________________________
(Street Address) (City)

____________________ __________ on the _____ day of _____________, 20____,
(State) (Zip Code)

agrees to the following conditions for the receipt of 835 electronic remittance advice transactions from Magellan Medicaid Administration, Inc. on behalf of the State of ______________________________ Pharmacy Management Program.

Section 1: The Parties agree, in regard to any Electronic Transactions between them:

(1) The only electronic transactions authorized and agreed to in this agreement are the transmission by Magellan Medicaid Administration to Partner of 835 remittance advices for pharmacy claims processed by Magellan Medicaid Administration on behalf of the State of ___________________________ Pharmacy Management Program.

(2) The electronic transactions shall comply with the requirements of HIPAA. Magellan Medicaid Administration may, at its sole discretion, change any definition, data condition, or use of a data element or segment in the transactions, as long as doing so, is not a violation of HIPAA or other applicable law.

(3) It is agreed that upon the successful implementation of the 835 transaction, partner will receive all remittance advices from Magellan Medicaid Administration via the 835 electronic transaction.

(4) The pharmacy or chain center certifies that they have a fully executed Electronic Data Interchange Trading Partner Agreement on file with the State of ____________________________ Medicaid Pharmacy Management Program.

(5) The chain center will promptly notify the State of ________________________ Medicaid Pharmacy Management Program of the names of providers either added to the chain center or discontinued from service (not applicable to independent pharmacies).

(6) The agreement may be terminated on thirty days' written notice by either party.

(7) This agreement will become effective when executed by both parties and may be amended only in writing, similarly executed.

(8) It is agreed that upon the successful implementation of the 835 transaction, partner will receive all remittance advices from Magellan Medicaid Administration via the 835 electronic transaction.

Section 2: General Terms and Conditions

(1) Each party will implement and maintain appropriate policies and procedures, and mechanisms to protect the confidentiality and security of PHI transmitted between the parties.

(2) This agreement is entered into solely between, and may be enforced only by the State of ________________________________ Medicaid Pharmacy Management Program and Magellan Medicaid Administration, Inc.. This agreement shall not be deemed to create any rights in third parties or to create any obligations of Magellan Medicaid Administration or partner to any third party.

(3) Each party shall maintain the confidentiality of PHI as required by law. This provision shall survive termination of this agreement.

(4) This agreement constitutes the entire agreement between the parties and contains a total integration of the rights and obligations of both parties with respect to the subject matter contained herein. This agreement may only be modified by amendment, which must be in writing and signed by both parties.

(5) If any part, term, or provision of this agreement shall be held illegal, unenforceable, or in conflict with any law of a federal, state, or local government having jurisdiction over this agreement, the validity of the remaining portion or portions shall not be affected thereby.

Section 3: This agreement shall be governed by the laws of the Commonwealth of Virginia. The undersigned hereby agrees to the terms and conditions of this Compliance and Confidentiality Agreement.

______________________________________ ____________________
(Signature) (Date)

____
(Print Name)

Company Name and Address

____

____

Company NPI______________________ Corporate Tax ID# _________________________

Section 4: Contact Information for Login and Password Owner (this entity will pull the 835 transmissions, may be chain center or third party agency)

____________________________________ ___________________________
(Contact Name) (Contact Telephone)

Company Name, if different from above: ___________________________________

Company Address, if different from above: ________________________________

Email address: ____

Mail or Fax Completed 835 Electronic Remittance Advice Agreement Form to:

Magellan Medicaid Administration, Inc.
Pharmacy Contract Management Group
11013 W. Broad Street
Suite 500
Glen Allen, VA 23060
Fax: 877-326-4731

For questions, please telephone: 800-441-6001.

MAGELLAN MEDICAID ADMINISTRATION, INC.
CONFIDENTIALITY AGREEMENT FOR NON-BUSINESS ASSOCIATES

The undersigned person or entity ("**You**"), in connection with the provision of services to, on behalf of, or related to, or the accessing of information of, Magellan Medicaid Administration, Inc. and/or its subsidiaries and/or affiliates (collectively, "**Magellan Medicaid Administration**") hereby agree as follows:

1. You are aware that, in the course of providing services to, on behalf of, or related to, or accessing of information of Magellan Medicaid Administration, You may deal with or have incidental access to information of a confidential or privileged nature related to members, providers, employees and/or Magellan Mediciad Administration itself, including but not limited to, trade secrets, strategic plans, customer lists, member information, contract terms, financial costs, pricing terms, sales data, business opportunities (whether for existing, new or developing business), ideas, methods, and processes ("**Magellan Medicaid Administration Confidential Information**").

2. Magellan Medicaid Administration Confidential Information shall not include information:
   - already properly within Your rightful possession (as demonstrated by written records) prior to the date of this Agreement;
   - independently developed by You;
   - already publicly available or becomes publicly available other than through a breach of this Agreement by You; or (d) lawfully disclosed to You by a third party who is not obligated to Magellan Medicaid Administration to retain such information in confidence.

3. You will keep all Magellan Medicaid Administration Confidential Information in the strictest of confidence. You will not disclose Confidential Information to anyone except Magellan Medicaid Administration employees or Magellan Medicaid Administration representatives who require access to such information to perform their duties. You agree to use all reasonable efforts to protect Magellan Medicaid Administration Confidential Information with the same degree of care used to protect your own confidential information. Unless expressly authorized by Magellan Medicaid Administration, You will not for any reason, disclose any Magellan Medicaid Administration Confidential Information, directly or indirectly, to any person, firm, corporation or business entity.

4. You agree that immediately upon the termination of the services to, on behalf of, or related to Magellan Medicaid Administration, You will either promptly deliver to Magellan Medicaid Administration, or destroy, all Magellan Medicaid Administration Confidential Information in Your possession or control which relate to the business of Magellan Medicaid Administration or which are the property of Magellan Medicaid Administration. Upon request of Magellan Medicaid Administration, you will certify the return or destruction of all Magellan Medicaid Administration Confidential Information.

5. You recognize that failure to comply with the terms and conditions of this Agreement may, among other things, be grounds for legal action by Magellan Medicaid Administration as well as basis for termination of any agreement you may have with Magellan Medicaid Administration.

6. In the event that You use any employees or agents to perform services for, on behalf of or related to Magellan Medicaid Administration, You will ensure that they agree to the same requirements contained herein.

7. You will defend, indemnify and hold Magellan Medicaid Administration harmless for any losses or damages arising from Your breach of this agreement, including any action by Your employees or agents in violation of the covenants contained in this agreement. You recognize that irreparable

damage will result to Magellan Medicaid Administration in the event of the violation of any covenant contained herein made by You, and agree that in the event of any such violation Magellan Medicaid Administration shall be entitled, in addition to its other legal or equitable remedies and damages, to temporary and permanent injunctive relief to restrain against such violations thereof by You and by all other persons acting for or with You, and to recover from You its reasonable attorney's fees and costs. Should a court of appropriate jurisdiction find any of the restrictions in any of the covenants contained herein unenforceable because it is overbroad, the court may modify such covenant to make its restrictions narrower and/or to make the covenant enforceable.

The undersigned hereby agrees to the terms and conditions of this Confidentiality Agreement.

______________________________________ ____________________
(Signature) (Date)

____
Print Name
Company Name and Address

____

____

Mail or Fax Completed Confidentiality Agreement for Non-Business Associates Form to:

Magellan Medicaid Administration, Inc.
Pharmacy Contract Management Group
11013 W. Broad Street
Suite 500
Glen Allen, VA 23060
Fax: 877-326-4731

For questions, please telephone: 800-441-6001.