Palmetto GBA
PARTNERS IN EXCELLENCE

Jurisdiction 1
Electronic Data Interchange Application

Line of Business Information

☐ Part A ☒ Part B ☐ CA ☐ NV ☐ HI*
*(*Includes Samoa, Guam and Northern Mariana Islands)*

Submitter Name: _____ 1 Date: _____

Trading Partner /Submitter ID: _____ 2

PPTN or DDE ID: _____

Type of Submitter: ☐ Software Vendor ☐ Billing Service 3 ☐ Provider ☐ Clearinghouse

Contact Person: _____

Phone: _____ Fax: _____

Address: _____

_____

City: _____ State: _____ ZIP: _____

E-mail Address*: _____

*Note: E-mail will be the primary method of communication.

Claim Submission Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT:Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report/Electronic Remittance Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT:Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report Response Format:	☒ File ☐ Report	
Data Compression	☐ PKZIP ☒ UNIX-Compress	
Name of Software Vendor: Medical Applications Corporation		
Vendor Security ID:		
PPTN or DDE Connectivity Vendor:	☐ IVANS ☐ VisionShare ☐ Other	

Providers For Whom Submitter Will Be Transmitting:

Provider Name: 4
Provider Number: 5 NPI: 7
☒ Submit Claims 6 ☐ Receive Electronic Remittances ☒ Receive Reports ☐ PPTN Online Inquiry or DDE

Provider Name:
Provider Number: NPI:
☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports ☐ PPTN Online Inquiry or DDE

Provider Name:
Provider Number: NPI:
☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports ☐ PPTN Online Inquiry or DDE

Please mail this form to: **Palmetto GBA**
Jurisdiction 1, AG-420
PO Box 100145
Columbia, SC 29202-3145

Or FAX to: 803-870-8035 (FAX)

Please retain a copy for your records.

April 2008 **EDI Application Form**

Where in Avanta do I find the information to fill out this form?
SEE THE NOTES BELOW!

Also, don't forget to fill out (if appropriate) items marked by the .

The information refernced below can be found by navigating from the Home screen to **[8] Edit Practice Files** followed by **[1] Physicians/Providers.** Use **[2] Change Physician/Provider** to view specific doctor information.

1. Physician #1 ONLY
   Page 2, Line [1]
2. Physician #1 ONLY
   Page 2, Line [2]
3. Select one or the other:
   "BIlling Service" if you bill for several clients
   or
   "Provider" if you perform your own billing (Individual or Group)

For the following section (identified by items 4, 5, 6, and 7) a "Provider" is uniquely identified in the system by their Medicare number (page 1, line [3]). Although you may have many physicians in your Practice, complete only one shaded box for each different Medicare number you encounter.

4. For an individual provider:
   Page 1, Line [1]
   For a group provider:
   Page 1, Line [8]
5. Page 1, Line [3]
6. Mark this box only if your office currently receives its EOBs electronically
7. For an individual provider:
   Page 2, Line [I]
   For a group provider:
   Page 1, Line [J]

Palmetto GBA
PARTNERS IN EXCELLENCE

Jurisdiction 1
Electronic Data Interchange Application

Line of Business Information:

☐ Part A ☒ Part B ☐ CA ☐ NV ☐ HI*

*(*Includes Samoa, Guam and Northern Mariana Islands)*

Submitter Name: _____ **Date:** _____

Trading Partner /Submitter ID: _____

PPTN or DDE ID: _____

Type of Submitter: ☐ Software Vendor ☐ Billing Service ☐ Provider ☐ Clearinghouse

Contact Person: _____

Phone: _____ **Fax:** _____

Address: _____

_____

City: _____ **State:** _____ **ZIP:** _____

E-mail Address*: _____

***Note: E-mail will be the primary method of communication.**

Claim Submission Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT:Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report/Electronic Remittance Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT:Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report Response Format:	☒ File ☐ Report	
Data Compression	☐ PKZIP ☒ UNIX-Compress	
Name of Software Vendor: Medical Applications Corporation		
Vendor Security ID:		
PPTN or DDE Connectivity Vendor:	☐ IVANS ☐ VisionShare ☐ Other	

Providers For Whom Submitter Will Be Transmitting:

Provider Name: _____

Provider Number: _____ **NPI:** _____

☒ Submit Claims ☐ Receive Electronic Remittances ☒ Receive Reports ☐ PPTN Online Inquiry or DDE

Provider Name: _____

Provider Number: _____ **NPI:** _____

☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports ☐ PPTN Online Inquiry or DDE

Provider Name: _____

Provider Number: _____ **NPI:** _____

☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports ☐ PPTN Online Inquiry or DDE

Please mail this form to:

Palmetto GBA
Jurisdiction 1, AG-420
PO Box 100145
Columbia, SC 29202-3145

Or FAX to: 803-870-8035 (FAX)

Please retain a copy for your records.

Providers For Whom Submitter Will Be Transmitting:

Provider Name:
Provider Number: **NPI:**
☐ **Submit Claims** ☐ **Receive Electronic Remittances** ☐ **Receive Reports** ☐ **PPTN Online Inquiry or DDE**

Provider Name:
Provider Number: **NPI:**
☐ **Submit Claims** ☐ **Receive Electronic Remittances** ☐ **Receive Reports** ☐ **PPTN Online Inquiry or DDE**

Provider Name:
Provider Number: **NPI:**
☐ **Submit Claims** ☐ **Receive Electronic Remittances** ☐ **Receive Reports** ☐ **PPTN Online Inquiry or DDE**

Provider Name:
Provider Number: **NPI:**
☐ **Submit Claims** ☐ **Receive Electronic Remittances** ☐ **Receive Reports** ☐ **PPTN Online Inquiry or DDE**

Provider Name:
Provider Number: **NPI:**
☐ **Submit Claims** ☐ **Receive Electronic Remittances** ☐ **Receive Reports** ☐ **PPTN Online Inquiry or DDE**

Provider Name:
Provider Number: **NPI:**
☐ **Submit Claims** ☐ **Receive Electronic Remittances** ☐ **Receive Reports** ☐ **PPTN Online Inquiry or DDE**

Provider Name:
Provider Number: **NPI:**
☐ **Submit Claims** ☐ **Receive Electronic Remittances** ☐ **Receive Reports** ☐ **PPTN Online Inquiry or DDE**

Provider Name:
Provider Number: **NPI:**
☐ **Submit Claims** ☐ **Receive Electronic Remittances** ☐ **Receive Reports** ☐ **PPTN Online Inquiry or DDE**

Provider Name:
Provider Number: **NPI:**
☐ **Submit Claims** ☐ **Receive Electronic Remittances** ☐ **Receive Reports** ☐ **PPTN Online Inquiry or DDE**

Please mail this form to: **Palmetto GBA**
Jurisdiction 1, AG-420
PO Box 100145
Columbia, SC 29202-3145

Or FAX to: 803-870-8035 (FAX)

Please retain a copy for your records.

Palmetto GBA
PARTNERS IN EXCELLENCE

A/B MAC Jurisdiction 1
California, Nevada, Hawaii,
Guam, American Samoa,
Northern Mariana Islands

EDI Enrollment (Agreement) Form and Instructions

The EDI Enrollment Form (commonly referred to as the EDI Agreement) should be submitted when enrolling for electronic billing. It should be reviewed and signed **only** by the providers to ensure each provider is knowledgeable of the enrollment request and the associated requirements.

Providers that have contracted with a third party (clearinghouse/network service vendor or a billing agent) are required to have an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to the viewing or use of Medicare Beneficiary data. These agreements are not to be submitted to Medicare, but are to be retained by the providers.

Providers are obligated to notify Medicare by letter of:

- Any changes in their billing agent or clearinghouse.
- The effective date of which the provider will discontinue using a specific billing agent or clearinghouse.
- If the provider wants to begin to use additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouse begins to use alternate software, the clearinghouse is responsible for notification in this instance.

Note: The binding information in an EDI Enrollment Form does not expire if the person who signed the form for a provider is no longer employed by the provider.

General Instructions:

- Please ensure that you include your **Medicare Provider Number** and **National Provider Identifier [NPI]** where requested on the EDI Enrollment Form.
- If the submitter will be submitting for multiple providers, this form must be completed by ***each*** provider whose claim data will be submitted.
- The entire form must be read carefully, dated with day, month and year.
- The name of the provider must be printed in the space provided, an authorized officer's name (printed), authorized officer's title and signature.
- When completed, the properly executed ***3-page*** **EDI Enrollment Form** must be returned ***with*** the **EDI Application** form to the following address:

  Palmetto GBA
  Jurisdiction 1, AG-420
  PO Box 100145
  Columbia, SC 29202-3145

Note: If the submitter will be an entity other than the provider, the submitter must complete the EDI Application form and the provider(s) must complete the EDI Enrollment Form(s). The EDI Application form must be returned with the EDI Enrollment Form enclosed for each applicable provider.

IMPORTANT NOTE:

The address shown on the EDI Enrollment Form must match the address that was submitted to our Provider Enrollment Department when enrolling for a provider number. If the address on the completed EDI Enrollment Form does not match, your entire EDI Enrollment Packet will be returned.

The National Provider Identifier (NPI) must be printed in the space provided on the EDI Enrollment Form. If this information is missing, the EDI Enrollment Form will not be processed.

Medicare Electronic Data Interchange Enrollment Agreement

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers, MACs, or FIs:

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contactor by itself, its employees, or its agents;

2. That it will not disclose any information concerning a Medicare beneficiary to any other person or organization, except CMS and/or its carriers, MACs, FIs or another contractor if so designated by CMS without the express written permission of the Medicare beneficiary or his/her parent or legal guardian, or where required for the care and treatment of a beneficiary who is unable to provide written consent, or to bill insurance primary or supplementary to Medicare, or as required by State or Federal law;

3. That it will submit claims only on behalf of those Medicare beneficiaries who have given their written authorization to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file;

4. That it will ensure that every electronic entry can be readily associated and identified with an original source document. Each source document must reflect the following information:

   - Beneficiary's name;
   - Beneficiary's health insurance claim number;
   - Date(s) of service;
   - Diagnosis/nature of illness; and
   - Procedure/service performed.

5. That the Secretary of Health and Human Services or his/her designee and/or the carrier, MAC, FI or other contractor if designated by CMS has the right to audit and confirm information submitted by the provider and shall have access to all original source documents and medical records related to the provider's submissions, including the beneficiary's authorization and signature. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable provisions of the Social Security Act, Federal regulations, and CMS guidelines;

6. That it will ensure that all claims for Medicare primary payment have been developed for other insurance involvement and that Medicare is the primary payer;

7. That it will submit claims that are accurate, complete, and truthful;

8. That it will retain all original source documentation and medical records pertaining to any such particular Medicare claim for a period of at least 6 years, 3 months after the bill is paid;

9. That it will affix the CMS-assigned unique identifier number (submitter identifier) of the provider on each claim electronically transmitted to the carrier, MAC, FI or other contractor if designated by CMS;

10. That the CMS-assigned unique identifier number (submitter identifier) or NPI constitutes the provider's legal electronic signature and constitutes an assurance by the provider that services were performed as billed;

11. That it will use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all transmissions of documents are authorized and protect all beneficiary-specific data from improper access;

12. That it will acknowledge that all claims will be paid from Federal funds, that the submission of such claims is a claim for payment under the Medicare program, and that anyone who misrepresents or falsifies or causes to be misrepresented or falsified any record or other information relating to that claim that is required pursuant to this agreement may, upon conviction, be subject to a fine and/or imprisonment under applicable Federal law;

13. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its carrier, MAC or FI or other contractor if designated by CMS shall not be used by agents, officers, or employees of the billing service except as provided by the carrier, MAC or FI (in accordance with §1106(a) of the Social Security Act (the Act);

14. That it will research and correct claim discrepancies;

15. That it will notify the carrier, MAC or FI or other contractor if designated by CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services (CMS) agrees to:

1. Transmit to the provider an acknowledgment of claim receipt;

2. Affix the FI/carrier/MAC or other contractor if designated by CMS number, as its electronic signature, on each remittance advice sent to the provider;

3. Ensure that payments to providers are timely in accordance with CMS's policies;

4. Ensure that no carrier, MAC, FI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, MAC, or FI, or from any subsidiary of the carrier, MAC, FI, other contractor if designated by CMS, or from any company for which the carrier, MAC, or FI has an interest. The carrier, MAC, FI, or other contractor if designated by CMS will make alternative means available to any electronic biller to obtain such services;

5. Ensure that all Medicare electronic billers have equal access to any services that CMS requires Medicare carriers, MACs, FIs, or other contractors if designated by CMS to make available to providers or their billing services, regardless of the electronic billing technique or service they choose. Equal access will be granted to any services the carrier, MAC, FI, or other contractor if designated by CMS sells directly, or indirectly, or by arrangement;

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form;

Note: Federal law shall govern both the interpretation of this document and the appropriate jurisdiction and venue for appealing any final decision made by CMS under this document. This document shall become effective when signed by the provider. The responsibilities and obligations contained in this document will remain in effect as long as Medicare claims are submitted to the carrier, MAC, FI, or other contractor if designated by CMS. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. In the event that the notice is mailed, the written notice of termination shall be deemed to have been given upon the date of mailing, as established by the postmark or other appropriate evidence of transmittal.

C. Signature

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name: _____

Address: _____

_____

City/State/Zip: _____

Phone: _____

Authorized Signature:_____

By (Print Name): _____

Title: _____

Date: _____ Medicare Provider Number _____

National Provider Identifier (NPI): _____

Complete ALL fields above and mail entire agreement (three pages) with ***original*** signature and ***with*** a copy of the **EDI Application form** to:

Palmetto GBA
Jurisdiction 1, AG-420
PO Box 100145
Columbia SC 29202-3145