

PAYER ID:

SUBMITTER ID:



Emdeon ERA Provider Information Form

**This form is to ensure accuracy in updating the appropriate account*

1 Provider Organization					
Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
2 Vendor <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					
3 Payer					
Payer ID					
Group ID	Individual Provider ID		NPI ID		
4 Confirmations					
Send Emdeon Claim Confirmations To:					
Special Instructions:					
<ul style="list-style-type: none"> All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted. SUBMIT COMPLETED FORM TO: Fax: (615) 231-4843 Email: batchenrollment@Emdeon.com 					
EMDEON REVISION FORM DATE:					



Important Note: The entity performing the billing must complete this form.

Incomplete or incorrect application **will be** returned.

1. General Information (Please do not submit profile prior to 10 days of the effective date.)

I am requesting to:	<input type="checkbox"/> Start billing electronically	<input checked="" type="checkbox"/> Add Electronic Remits Notice (ERN) (835 Report)
	<input type="checkbox"/> Delete ERN	<input type="checkbox"/> Change existing Trading Partner
	<input type="checkbox"/> Other (Complete Section 9)	

Effective Date: _____ (Profile will be held no more than 10 days.)

2. Provider Information

Submitter ID# (If known for existing EDI Billers):	EMDID		
Practice Name:			
Mailing Address:			
City, State, Zip:			
Contact Name:		Phone #:	
E-mail:		Fax #:	

3. PTAN & NPI Numbers (Please list the Group PTAN and NPI numbers below. If a Group PTAN does not apply, list the Individual PTAN and NPI numbers. In order to complete the EDI application, both the PTAN and NPI numbers are required.)

Group PTAN #:		Individual PTAN #:		NPI #:	
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4. Claim Transmission Information (Mark all applicable boxes below.)

Connection Method (If nothing is selected, Stratus will be the default.):	<input type="checkbox"/> Stratus (dial-up connection to CIGNA)	
	<input type="checkbox"/> Other (Please be specific): _____	
Format:	<input type="checkbox"/> ANSI X12N 837 v. 4010A1	
Billing Software (Shade in circle of selection):	<input type="checkbox"/> Program In-House	Medicare Claims Express (MCE): <input type="checkbox"/> MCE for Primary Billing (You will automatically be set-up to receive ERL & ERN files). <input type="checkbox"/> MCE for Medicare Secondary Payer (MSP)
	<input type="checkbox"/> Vendor Software	
	<input type="checkbox"/> Billing Service	
	<input type="checkbox"/> Clearinghouse	

5. Trading Partner & Third-Party Information (Include information pertaining to the selected billing service, clearinghouse, and/or software vendor.)

	Software Vendor:	Billing Service:	Clearinghouse:
Name:			EMDEON
Address:			3055 Lebanon Pike STE 1000
City, State, Zip:			Nashville, TN 37214
Phone #:			866.924.4634
Fax #:			615.231.4843
Contact:			Enrollment Help Desk
Submitter ID (If one assigned for all Providers):			EMDID



ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

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 contractor 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 or FIs, 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 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;



CIGNA Government Services



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 six years, three 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;
10. That the CMS-assigned unique identifier number (submitter identifier) 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 shall not be used by agents, officers, or employees of the billing service except as provided by the carrier or FI (in accordance with §1106(a) of Social Security Act (the Act));
14. That it will research and correct claim discrepancies;
15. That it will notify the carrier or FI or CMS within two 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' policies;
4. Ensure that no carrier, MAC, FI or other contractor may require the provider to purchase any or all electronicservices from the carrier, MAC or FI or from any subsidiary of the carrier, MAC or FI or from any company for which the carrier, MAC, or FI has an interest. The



carrier, MAC, or FI 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 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 or FI sells directly, or indirectly, or by arrangement;
- 6. Notify the provider within two business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

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 CMS or 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 _____
 Title _____
 Address _____
 City/State/Zip _____
 By _____
 Title _____
 Date _____

Please fill in **ALL** the blank lines above and **mail or fax** the completed form along with the Part B EDI Customer Profile to the following:

CIGNA Government Services
ATTN: EDI Department
PO Box 690
Nashville, TN 37202
Fax: 615.782.4653