

PAYER ID:

SUBMITTER ID:



## Emdeon ERA Provider Information Form

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

<b>1 Provider Organization</b>					
Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
<b>2 Vendor</b> <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					
<b>3 Payer</b>					
Payer ID					
Group ID	Individual Provider ID		NPI ID		
<b>4 Confirmations</b>					
Send Emdeon Claim Confirmations To:					
Special Instructions:					
<ul style="list-style-type: none"> <li>• All Payer Registration forms must contain original signatures, no stamped signatures or photocopies are accepted.</li> <li>• SUBMIT COMPLETED FORM TO:  Emdeon  Donelson Corporate Ctr Bldg 3  3055 Lebanon Pike Ste 1000  NASHVILLE, TN 37214-2230</li> </ul>					
RHHI AVAILABLE FOR THE FOLLOWING STATES -- AR, LA, NM, OK, AND TX.					
EMDEON REVISION FORM DATE:					

## EDI APPLICATION FORM INSTRUCTIONS

The purpose of the **SC Part A & RHHI EDI Application Form** is to enroll providers, software vendors, clearinghouses and billing services as electronic submitters and recipients of electronic claims data. **It is important that instructions are followed and that all required information is completed. Incomplete forms will be returned to the applicant, thus delaying processing.**

**Please retain a copy of this completed form for your records.**  
You must submit a completed EDI Application Form when submitting additional EDI forms.

Providers are not permitted to share their personal EDI access number (Submitter ID) or their password to:

- Any billing agent, clearinghouse/network service vendor
- To anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility or to determine the status of a claim
- Any non-staff individual or entity

The EDI Submitter ID and password act as an electronic signature, therefore the provider would be liable if any entity performed an illegal action while using that EDI Submitter ID and password. Likewise, a provider's EDI Submitter ID and password is not transferable, meaning that it may not be given to a new owner of the provider's operation. New owners must obtain their own EDI Submitter ID and password.

The field descriptions listed below will aid in completing the form properly. There are two (2) pages to the application form. The first page is required and the second page should be used only if additional providers need to be listed.

Form Field Name	Instructions for Field Completion
<b>Action Requested:</b> Add Provider(s) Change/Update Delete Apply for New Submitter ID Apply for PS&R ID	Indicate the action to be taken on the application form. <ul style="list-style-type: none"> <li>• If you need to add additional providers to an existing submitter ID, check <b>Add Provider(s)</b>.</li> <li>• If you request to change or update information about the Submitter and/or Provider, check <b>Change/Update</b> and be sure to include your current Submitter ID.</li> <li>• If you request to delete a provider(s), check <b>Delete</b> and be sure to include your submitter ID.</li> <li>• If you are a new applicant, check <b>Apply for New Submitter ID</b>.</li> <li>• If you are applying for a Provider Statistical and Reimbursement (PS&amp;R) ID, check <b>Apply for PS&amp;R</b>.</li> </ul>
<b>Submitter ID:</b>	The submitter ID is used by the submitter to communicate with Palmetto GBA electronically. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID. For changes or additions, enter the Submitter ID to which the change/additions should be applied. Submitters who have a PS&R and/or DDE submitter ID should also enter it in the spaces provided.
<b>Date:</b>	Please enter the date the application is completed.
<b>PS&amp;R ID:</b>	The PS&R ID is used by the submitter to access our GPNet to download the PS&R reports. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID. Note: PS&R reports are only available through GPNet.
<b>DDE ID:</b>	The DDE User ID is used by the submitter to directly access our claims processing system. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID, if requested. For requests to <b>Add Provider(s)</b> or make a <b>Change</b> , please enter your existing DDE Users ID. If you are a billing service or clearinghouse, please complete the Addendum to DDE.

Form Field Name	Instructions for Field Completion
<b>Submitter Name:</b>	Enter the name of the entity (provider, software vendor, billing service or clearinghouse) that will actually be communicating electronically with Palmetto GBA.
<b>Type of Submitter:</b>	Check the appropriate box. If Billing Service/Clearinghouse is selected, appropriate addendums must be completed.
<b>Contact Person:</b>	The name of the submitter's primary EDI contact. This is the person Palmetto GBA will contact if there are questions regarding the application or future questions about their communications.
<b>Phone:</b>	The area code and phone number of the Contact Person listed.
<b>FAX:</b>	The FAX number for this location.
<b>Address:</b>	The mailing address of the submitter.
<b>City, State, Zip:</b>	The city, state and zip code of the submitter.
<b>E-mail Address:</b>	The e-mail address of the contact person listed. <b>Note: This will be the primary method of communication.</b>
<b>Claim Submission Mode of Communication:</b>	There are four available modes of communication modes that can be used for claim submission. Check <b>only one</b> . <ul style="list-style-type: none"> <li>• <b>GPNet:</b> Asynchronous communication with the Gateway</li> <li>• <b>Connect Direct – NDM:</b> Network Data Mover</li> <li>• <b>Dial-up FTP:</b> File transfer protocol transmission via GPNet – not Internet.</li> <li>• <b>DDE:</b> Should be checked by submitters who are requesting Direct Data Entry as their <b>sole</b> mode of electronic claim submission.</li> </ul>
<b>Electronic Remittance Retrieval Mode of Communication:</b>	Check <b>only one</b> mode of communication that will be used. <ul style="list-style-type: none"> <li>• <b>GPNet Asynchronous</b> should be checked for asynchronous communication with Palmetto GBA's GPNet.</li> <li>• <b>CONNECT:Direct (NDM)</b> should be checked for report retrieval via GPNet</li> <li>• <b>Dial-up FTP</b> should be checked for file transfer protocol report retrieval via GPNet.</li> </ul>
<b>Report Response Format:</b>	Check the format in which you will receive GPNet Claims Acceptance Responses.
<b>Data Compression:</b>	To received files compressed for faster transmission, indicate which data compression utility you support.
<b>PS&amp;R Mode of Communication</b>	The only mode of communication available to SC Part A providers for PS&R retrieval is through <b>GPNet Asynchronous</b> .
<b>Name of Software Vendor</b>	Indicate the name of the software vendor you are using, if applicable.
<b>Vendor ID:</b>	Include Vendor ID number if known.
<b>Name of DDE Connectivity Vendor:</b>	Indicate the name of the Direct Data Entry (DDE) Connectivity Vendor you are using or plan to use, if applicable
<b>Providers For Whom Submitter Will Be Communicating Electronically:</b>	
<b>Provider Name:</b>	List each provider whose bills will be submitted by the submitter named above. (If additional providers need to be listed, indicate each one separately on the <i>Multiple Providers List</i> form.)
<b>Provider Number:</b>	Indicate the 6-digit Medicare Provider Number for each provider listed.
<b>NPI:</b>	Include the National Provider Identifier (NPI).
<b>Enrollment Attached: Y/N</b>	Indicate "Y" for Yes or "N" for No. A properly executed 3-page <b>EDI Enrollment Agreement</b> must be attached for <i>each</i> provider listed. <b>Palmetto GBA will not activate a submitter ID for any provider without a properly executed enrollment form.</b>
<b>Submit Claims:</b>	Check this box if the application is for the submitter to submit claims electronically for this provider.

Form Field Name	Instructions for Field Completion
<b>Receive Reports:</b>	Check this box if the submitter wants to receive response reports electronically for the provider indicated.
<b>Receive Electronic Remittances:</b>	Check this box if the submitter wants to receive Electronic Remittances for the provider indicated. Provider must be submitting claims electronically to receive Electronic Remittances.

Once you have completed the application form, **please retain a copy for your records** and mail the original to the address listed below. Your Submitter ID and software (if applicable) will be processed within 20 business days of receipt of completed forms. Submit completed form to:

**Palmetto GBA**  
 Medicare Part SC A / RHHI EDI, AG-420  
 PO Box 100145  
 Columbia SC 29202-3145



**SC Part A & RHHI  
Electronic Data Interchange Application**

Action Requested:  Add Provider(s)  Change / Update  Delete  
 Apply for New Submitter ID  Apply for PS&R ID

Submitter ID (if available): \_\_\_\_\_ Date: \_\_\_\_\_

PS&R ID: \_\_\_\_\_ DDE ID: \_\_\_\_\_

Submitter Name: \_\_\_\_\_

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:	<input type="checkbox"/> GPNet Asynchronous <input type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Dial-up FTP <input type="checkbox"/> DDE
Electronic Remittance Retrieval Mode of Communication:	<input type="checkbox"/> GPNet Asynchronous <input type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Dial-up FTP
Report Response Format:	<input type="checkbox"/> File	<input type="checkbox"/> Report
Data Compression:	<input type="checkbox"/> Uncompressed (GPNet Default) <input type="checkbox"/> PKZIP	<input type="checkbox"/> UNIX-Compress
PS&R Mode of Communication:	<input checked="" type="checkbox"/> GPNet Asynchronous	
Name of Software Vendor:	Vendor Security ID:	
Name of DDE Connectivity Vendor	<input type="checkbox"/> IVANS <input type="checkbox"/> VisionShare <input type="checkbox"/> Other:	

**Providers for Whom Submitter Will Be Transmitting:**

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_ NPI: \_\_\_\_\_

Enrollment Attached?  Yes  No  Submit Claims  Receive Reports  Receive Electronic Remittances

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_ NPI: \_\_\_\_\_

Enrollment Attached?  Yes  No  Submit Claims  Receive Reports  Receive Electronic Remittances

Submit completed form to: **Palmetto GBA** **Please retain a copy for your records.**  
 Medicare Part SC A / RHHI EDI, AG-420  
 PO Box 100145  
 Columbia SC 29202-3145

**Please retain a copy for your records. You must submit a completed EDI Application Form when submitting additional EDI forms.**



**SC Part A & RHHI  
Electronic Data Interchange Application**

**Multiple Providers List**

**Date:** \_\_\_\_\_

**PROVIDERS FOR WHOM SUBMITTER WILL BE TRANSMITTING:**

Action Requested:       Add Provider               Change / Update               Delete Provider

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_              NPI: \_\_\_\_\_

Enrollment Attached?       Submit Claims               Receive Reports               Receive Electronic  
 Yes       No

Action Requested:       Add Provider               Change / Update               Delete Provider

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_              NPI: \_\_\_\_\_

Enrollment Attached?       Submit Claims               Receive Reports               Receive Electronic  
 Yes       No

Action Requested:       Add Provider               Change / Update               Delete Provider

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_              NPI: \_\_\_\_\_

Enrollment Attached?       Submit Claims               Receive Reports               Receive Electronic  
 Yes       No

Action Requested:       Add Provider               Change / Update               Delete Provider

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_              NPI: \_\_\_\_\_

Enrollment Attached?       Submit Claims               Receive Reports               Receive Electronic  
 Yes       No

Action Requested:       Add Provider               Change / Update               Delete Provider

Provider Name: \_\_\_\_\_

Provider Number: \_\_\_\_\_              NPI: \_\_\_\_\_

Enrollment Attached?       Submit Claims               Receive Reports               Receive Electronic  
 Yes       No

## EDI ENROLLMENT AGREEMENT INSTRUCTIONS

The following EDI Enrollment 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 Agreement does not expire if the person who signed the form for a provider is no longer employed by the provider.

### General Instructions:

- 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 Agreement** must be returned *with* the **EDI Application** form to the following address:

**Palmetto GBA**  
Medicare SC Part A / RHHI EDI, 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 Agreement(s). The **EDI Application** form must be returned with the **EDI Enrollment Agreement** enclosed for each applicable provider.

### IMPORTANT NOTICE PLEASE READ:

**The address shown on the EDI Enrollment Agreement 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 Agreement *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 Agreement. If this information is missing, the **EDI Agreement will not be processed.**

# MEDICARE ELECTRONIC DATA INTERCHANGE ENROLLMENT AGREEMENT

The undersigned provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS's contractors.

## **A. The Provider Agrees:**

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, DMERC, 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
  - Procedure/service performed
5. That the Secretary of Health and Human Services or his/her designee and/or the carriers, DMERC, FIs 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 carriers, DMERC, FIs or another contractor if so designated by CMS.

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, DMERC or FI or other contractors if designated by CMS, shall not be used by agents, officers, or employees of the billing service except as provided by carrier, DMERC or FI or other contractors if designated by CMS (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, DMERC or FI or other contractors if designated by CMS or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

**B. The Centers for Medicare & Medicaid Services will:**

1. Transmit to the provider an acknowledgement of claim receipt.
2. Affix the FI/carrier/DMERC 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, DMERC, FI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, DMERC, FI, or other contractor if designated by CMS or from any subsidiary of the carrier, DMERC, FI, or other contractor if designated by CMS or from any company for which the carrier, DMERC, or FI has an interest. The carrier, DMERC, 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 carrier, DMERC, FI, or other contractor 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, DMERC, FI, or other contractor if designated by CMS sells directly, indirectly, or by arrangement.
6. Notify the provider within 2 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 the 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 carrier, DMERC, FI, or other contractor if designated by CMS. Either party may terminate this arrangement by giving the other party (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/Supplier Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

By (Print Name): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_ Medicare Provider Number \_\_\_\_\_

National Provider Identifier (NPI) \_\_\_\_\_

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Complete ALL fields above and mail entire agreement (three pages) with *original* signature to:

Palmetto GBA  
 Medicare Part SC A / RHHI EDI, AG-420  
 PO Box 100145  
 Columbia SC 29202-3145

## ADDENDUM TO ELECTRONIC REMITTANCE ENROLLMENT FORM FOR BILLING SERVICES AND CLEARINGHOUSES

In order to have access to Electronic Remittances, an entity must be submitting *initial* claims electronically for the provider. We cannot provide Electronic Remittance access to a collection agency or any entity that bills after the original biller.

I hereby authorize \_\_\_\_\_ to obtain Electronic Remittance on  
BILLING SERVICE/CLEARINGHOUSE

behalf of \_\_\_\_\_.  
PROVIDER NAME

I understand that Electronic Remittances contain payment information concerning my processed Part A claims. I am authorized to endorse this addendum on behalf of my company.

I agree to:

1. Be responsible for all activities of the billing service/clearinghouse while they are engaged in performing functions for my provider number.
2. Not share or exchange Submitter / User IDs or passwords.
3. Report to Palmetto GBA any suspected misconduct by the billing service/clearinghouse.
4. Notify Palmetto GBA in writing of any change in this authorization using the Provider Change form located on the [www.PalmettoGBA.com](http://www.PalmettoGBA.com) Web site.

**PROVIDER INFORMATION:**

Provider Number	National Provider Identifier (NPI)
Provider Name	Name/Title (Please Print)
Address	Signature
City/State/Zip	Date
E-mail Address	Phone

**BILLING SERVICE/CLEARINGHOUSE INFORMATION:**

SUBMITTER ID*	SUBMITTER NAME*
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\*Please indicate the **Submitter ID** of the *Billing Service or Clearinghouse* that will be doing your billing.

Submit completed form to: Palmetto GBA  
 Medicare SC Part A / RHHI EDI, AG-420  
 PO Box 100145  
 Columbia SC 29202-3145