

**FLORIDA MEDICARE HOSPITAL ERA****For Initial Enrollment with this payer:**

- If you have NOT submitted claims electronically to this payer, the Payer requires Payer Registration forms. Please complete all fields on the following page(s) as well as the attached Payer Registration forms and return to Emdeon for processing.
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site <http://www.emdeon.com>.

For Re-Enrollment (COS Change of Service) with this payer:

- If you have submitted claims electronically to this payer in the past, either directly or through another clearinghouse, and would like to submit through Emdeon, the Payer requires payer registration forms.
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site <http://www.emdeon.com>.

If you are already APPROVED by this payer to submit through Emdeon:

- If you have already received an approval from this payer to submit claims electronically through Emdeon, you must notify Emdeon so that we may process your approval in our enrollment systems. Please submit a **Client Provided Approval Form** to Enrollment for processing.
 - You may obtain the form from our enrollment web site <http://www.Emdeon.com>.
 - The Client Provided Approval form must be submitted to: payerregistration@Emdeon.com , or faxed to 615-885-3713.

Payer Registration Reminders:

- Please keep a copy of all forms for your records.
- Please verify that all pages in the agreement are included when mailing.
- Please ensure that all required fields are completed and legible.
- Please provide a physical address below in case we need to Fed-Ex your agreement back to you.
- Please remember to sign and date all documents. Your software vendor must be certified to send All-Payer claims to Emdeon. Please contact your vendor if you have questions regarding certification.
- To obtain forms or additional payer information, visit our website: <http://www.Emdeon.com>.



FLORIDA MEDICARE HOSPITAL ERA

Instructions for submitting Payer Registration Forms:

- You must include this page when submitting Payer Registration forms to Emdeon
- Registration forms must be submitted to the address or fax number below
- To obtain forms or additional payer information, visit our website: <http://www.Emdeon.com>.

This Registration form is for a:			
		<input type="checkbox"/> Provider	<input type="checkbox"/> Group
Name*			
Physical Address*			
City, State, Zip*			
Contact Name*			
Contact Phone			
Contact Fax			
Contact Email Address [§]			
NPI ID*	Group ID*		
	Provider ID*		
Tax ID*	Site ID*		
Vendor Submitter ID*	Division ID*		
Vendor Name*			
Additional Info			

* Required Information if applicable.

[§] All Approval Notifications will be sent to this address

Submit Original Payer Registration forms that require original signatures to:

Emdeon Business Services
 Attn: Enrollment Dept
 Donelson Corporate Ctr Bldg 3
 3055 Lebanon Pike Ste 2000
 Nashville, TN 37214

For all other forms:

Fax: (615) 231-4843

Email: batchenrollment@Emdeon.com

To avoid claim rejection, please do not submit electronic claims before receiving [Emdeon Approval Notification](#).



**MEDICARE
Electronic Data Interchange**

**General Completion Instructions for
Electronic Data Request (EDR) Form**

The Electronic Data Request (EDR) Form is designed for Medicare providers to apply for or revise existing information pertaining to the Electronic Remittance Advice (ERA) or the Electronic Claim Status (ECS) Request and Response transaction. **Prior to applying for one of these transactions, check with your software support vendor to ensure you have the necessary software to conduct the transaction.**

Please review the following completion instructions carefully to ensure all required information is provided. If all required information is not provided, the form will be returned to the sender/submitter for the additional information.

SECTION A: Request Type. This section is required.

New Sender/Submitter: If you do not have a sender/submitter number to transmit or receive electronically, a New Installation/Change of Vendor Form is required prior to being set up to receive electronic remittances or electronic claim status. You may submit this form (EDR) with the New Installation/Change of Vendor Form. Indicate in this section which transaction you are applying for.

Existing Sender/Submitter: If you currently have a sender/submitter number, indicate which transaction you want to add or delete. Please note the PC-ACE Pro32® software does not support the electronic claim status transaction.

SECTION B: Sender/Submitter Information. All fields in this section are required unless otherwise indicated as optional or conditional.

The sender/submitter information refers to the entity that will conduct the electronic exchange of the transaction. Third party billers need to apply for their own sender/submitter number. **A third party biller cannot use a Medicare Provider's assigned Sender/Submitter number.**

Sender/Submitter Number (Conditional): Indicate the sender/submitter number that will be used to transmit or receive electronic transactions. Required when adding a transaction to or deleting a transaction from an existing sender/submitter number.

Sender/Submitter Name: Indicate the name of the sender/submitter.

Mailing Address: Indicate the address of the sender/submitter.

City/State/Zip: Indicate the city, state and zip for the sender/submitter's address indicated above.

Contact Name/Position or Title: Indicate the name and title of the person to be contacted in case of inquiries concerning this form.

Telephone: Indicate the telephone number of the sender/submitter in case of inquires concerning this form.

Fax/Email Address (Optional): Indicate the fax number and email address of the sender/submitter in case of inquires concerning this form.

SECTION C: VENDOR INFORMATION. All fields in this section are required unless otherwise indicated as optional.

Vendor Name: Indicate the software support vendor's name.

Vendor Address (Optional): Indicate the software support vendor's address.

City/State/Zip (Optional): Indicate the software support vendor's city, state and zip for the address as shown above.

Contact Name/Position/Title (Optional): Indicate the name and title of the contact person for the software support vendor.

Telephone and Fax Number (Optional): Indicate the contact person's telephone and fax number.

SECTION D: DEFAULT DELIMITERS (Optional): Please contact your software support vendor for information about the default delimiters. If your software supports the default delimiters, please leave blank. If you are using the PC-ACE Pro32® software, leave blank.

SECTION E: Signature, Title, Provider's Name and Medicare Provider Number (if known), Effective Date, National Provider Identifier (NPI), Provider's Tax Identification Number / Social Security Number. All fields in this section are required.

The signature of the provider or authorized party for the provider is required. Indicate the title of the provider or authorized party, Medicare billing provider's name, Medicare provider number (if known), the effective date, the billing provider's NPI (if the provider is a member of a group indicate the group's NPI), the billing provider's Tax Identification Number / Social Security Number.

NOTE: When the provider is using a third party, e.g., clearinghouse, billing service, etc., to exchange EDI transactions, the signature serves as the provider's authorization for that third party to act on behalf of the provider for the indicated EDI transaction(s). The provider is required to have on file, an agreement signed by the 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 viewing or use of Medicare beneficiary data. **A representative from a billing service or clearinghouse is not authorized to sign on behalf of the provider.**

You may fax your Electronic Data Request Form for processing. However, if the provider does not have an EDI Enrollment Form on file, please submit the Electronic Data Request form with the signed EDI Enrollment Form. Failure to have an EDI Enrollment form on file will result in the EDR form being returned.

FAX OR MAIL COMPLETED FORMS TO:

Mailing Address:

Medicare EDI
PO Box 44071 – 14T
Jacksonville, FL 32231-4071

Telephone and Fax Numbers:

FL (904) 791-8767, option 2
CT (203) 639-3160, option 1
Fax (904) 791-6692

Physical Address:

Medicare EDI
532 Riverside Ave. 14T
Jacksonville, FL 32202-4918

SECTION C: VENDOR INFORMATION. The software support vendor can assist with this section. **All fields in this section are required unless otherwise indicated as optional.**

Vendor Name: _____

Vendor Address (Optional): _____

City/State/Zip (Optional): _____

Contact Name (Optional): _____ Position/Title (Optional): _____

Telephone Number (Optional): _____ Fax Number (Optional): _____

SECTION D (Optional): DEFAULT DELIMITERS. Contact your software support vendor for assistance with this section. If you are using the PC-ACE Pro32® software, leave blank. If your software supports the default delimiters, please leave blank.

The default delimiters returned on electronic remittance advice are:

- * (2A hex value) for element delimiter;
- > (3E hex value) for sub-element delimiter; and
- Line Feed (0A hex value) for segment delimiter.

If alternate values are required, please indicate below:

Element _____ Sub-element _____ Segment _____

SECTION E: PROVIDER SIGNATURE, TITLE, MEDICARE BILLING PROVIDER NAME, MEDICARE PROVIDER NUMBER (IF KNOWN) EFFECTIVE DATE, NPI, PROVIDER'S TAX IDENTIFICATION / SOCIAL SECURITY NUMBER: This section is required. Please copy and complete this page for each additional provider.

“By signing below, I authorize the indicated electronic data request addition or deletion.

X _____ / _____
 (Signature) (Title)

MEDICARE PART “A” PROVIDER: _____ / _____
 (FL ONLY) Name of Provider Medicare Provider Number
 (If known)

MEDICARE PART “B” PROVIDER: _____ / _____
 Name of Provider Medicare Provider Number
 (If known)

EFFECTIVE DATE: _____ NPI: _____
 (National Provider Identifier)

BILLING PROVIDER'S TAX IDENTIFICATION NUMBER / SSN: _____

****Attention: The provider is required to notify Medicare EDI, in writing, in advance of any changes impacting their use of EDI and the effective date of such changes. Medicare EDI must be notified if the provider will begin, change, or discontinue using a billing service, clearinghouse, or other third party. The form necessary to notify us of such changes is the EMC Change of Information form that can be downloaded from the Web site www.fcso.com. Select Medicare Electronic Services-Using EDI-Forms.**

If you have questions about the completion of this form, please refer to the "General Completion Instructions" of the EDR form.

Mailing Address:

Medicare EDI
PO Box 44071 – 14T
Jacksonville, FL 32231-4071

Telephone and Fax Numbers:

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