

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

- **Please be sure to have Authorization Letter Completed on Provider Letter Head**
- Registration with Emdeon takes 28 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>.

**FAX COMPLETED FORMS DIRECT TO PAYER**

**Fax: 207-253-3646**

Please print on Provider's Letterhead

### National Government Services Medicare Part A Letter of Authorization

This form must be used when a provider is giving a third party authorization to submit claims, receive remittance advices, check status and eligibility, or access the Medicare Online System (FISS/CWF). This form must be filled out by the provider and signed by the provider's Authorized Medicare Administrator.

\_\_\_\_\_  
(Facility Name)

\_\_\_\_\_  
(Address)

\_\_\_\_\_  
(City) (State) (ZIP)

\_\_\_\_\_  
(Contact) (Phone)

Effective \_\_\_\_/\_\_\_\_/\_\_\_\_ please authorize EMDEON BUSINESS SERVICES  
(Date) (Third Party Name)

to conduct the following checked electronic transactions on our behalf.

- Medicare Online System (FISS/CWF)
- 837 4010 A1 Electronic Claims
- 835 4010 A1 Electronic Remittance Advice
- 276/277 Claim Status Request/Response

This access only applies to the following Medicare provider numbers:

\_\_\_\_\_

Providers are required to report in advance if they will begin or discontinue use of a clearinghouse or billing agent for submission or receipt of any of their EDI transactions, if they will begin to use a different clearinghouse or billing agent for any EDI transactions, if they want to begin to use the HIPAA claim or remittance advice transaction, or if they plan to discontinue use of one or more EDI transactions, and that this notification must be in writing and submitted via mail or fax.

\_\_\_\_\_  
Provider's Authorized Medicare Administrator (Print) Title

\_\_\_\_\_  
Provider's Authorized Medicare Administrator (Sign) Date

**Fax or Mail to:**  
National Government Services, Inc.  
P.O. Box 4837  
Syracuse, NY 13221-4837  
**Fax: 207-253-3646**

**National Government Services, Inc.**  
**Medicare Part A Intermediary**  
**Request for Medicare Part A Electronic Remittance Advice (ERA)**

This form must be completed and signed by the Medicare provider. Remittance files are available on daily. Please call EDI at 888-476-7218 Option 5 if you have any questions regarding viewing or downloading your ERA.

**\*Eight Character Sender ID:** MEWEBMDO  
*(Required Field – Available from EDI or your Clearinghouse)*

INTERNAL USE ONLY
DB: <input type="checkbox"/>
EDI: <input type="checkbox"/>
FORMAT:
TEST:
TYPE:
GROUP:
SUPP DATE: ____/____/____
EMAIL: <input type="checkbox"/>
REQ DATE: ____/____/____

**Provider Information:**

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

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

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone : (\_\_\_\_) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

<u>Choose One:</u>	<u>Medicare Provider Numbers</u>
<input type="checkbox"/> Stop Current ERA Production Format <input type="checkbox"/> Start 835 Test ERA File (ANSI 4010A1) <input checked="" type="checkbox"/> Start 835 Production ERA File (ANSI 4010A1)	 _____  _____  _____
<p><b>It is the responsibility of the facility to maintain reliable backups all electronic remittance files. EDI is only able retain 90 days of ERA files.</b></p>	

**Terms of Use:**

This is to certify that the person named below has requested to receive or discontinue receiving an Electronic Remittance Advice (ERA) from their Medicare Part A intermediary, Associated Hospital Service. The authorized signer is accountable for ensuring that the remittance data is backed up and that the data is not used in a way that violates HIPAA Privacy Rules. **Paper remittances will be discontinued thirty days after the provider number has been set up for Production ERA.**

\_\_\_\_\_  
Authorized Medicare Administrator Name (Print)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Authorized Medicare Administrator Signature

\_\_\_\_\_  
Date

**Fax or Mail to:**  
National Government Services, Inc.  
P.O. Box 4837  
Syracuse, NY 13221-48376  
**Fax: 207-253-3646**

INTERNAL USE ONLY
HPTP8 : <input type="checkbox"/>
HPTP6: <input type="checkbox"/>
ROUTE: <input type="checkbox"/>
Verification Date: ____/____/____