

PAYER ID:

SUBMITTER ID:



emdeon™

Emdeon **Claims** 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 *(Emdeon certified vendor used to submit files to Emdeon)*

| | | | | | |
|----------------|--|---------------------|--|-------------|--|
| 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 original signatures, NO stamped signatures or photocopies are accepted. • SUBMIT COMPLETED FORM TO: Emdeon Donelson Corporate Ctr Bldg 3 3055 Lebanon Pike Ste 1000 NASHVILLE, TN 37214-2230 | | | | |
| | | | | | |
| EMDEON REVISION FORM DATE: | | | | | |



A CMS Contracted Intermediary and Carrier
Medicare Electronic Data Interchange Department

Dear Provider:

Thank you for your interest in Electronic Media Claims (EMC). Enclosed is a summary of the available electronic claims services for Medicare Part A/B providers. Also enclosed are the necessary applications, enrollment forms and instructions for their completion.

Section 1 - General EDI Enrollment Documents – contains the **required** enrollment documents that must be completed, signed and returned to our office prior to initiation of electronic claims submission or inquiry.

Section 2 - Free Billing Software

Section 3 - Testing Requirements

The Administrative Simplification Compliance Act (ASCA) prohibits Medicare coverage of claims submitted to Medicare on paper, except in limited situations.

All initial claims for reimbursement from Medicare must be submitted electronically as of October 16, 2003, with limited exceptions.

TrailBlazer Health Enterprises, LLC accepts Medicare claims submitted electronically using the ANSI ASC X12N 837 v4010A1 format.

We are committed to making your transition to EMC as smooth as possible. If you have any questions regarding the information contained in this package, please feel free to contact the TrailBlazer EDI Technology Support Center toll free at (866) 749-4302.

Be Compliant: Take Control of your Accounts Receivable

Sign up today to receive your remittances electronically and be ahead of the game. Download and print your remittances more quickly. CMS is focused on increasing the number of providers who receive their remittances electronically and on decreasing the printing and mailing costs associated with hard copy remittances. Complete your forms today!

Important Note on Staying Up-To-Date Online

Register on the TrailBlazer Web site (<http://www.TrailBlazerHealth.com>) to receive EDI news electronically. By selecting “Listserv” (which displays at the top of all pages) and completing a user profile, you will be notified via e-mail when new or important EDI information is added to our Web site. If you have already registered, please ensure your profile has been updated for all new applicable EDI categories.

TRAILBLAZER HEALTH ENTERPRISES, LLC SECTION 1 – GENERAL EDI ENROLLMENT DOCUMENTS

The following documents are required to enroll for EDI:

- **Medicare Electronic Data Interchange Application**
The purpose of the EDI application is to enroll providers, software vendors, clearinghouses and billing services as electronic submitters. Please follow the instructions carefully when completing the application. Incomplete forms will be returned to the applicant, thus delaying processing.
- **Medicare Electronic Data Interchange Enrollment Agreement**
The EDI enrollment agreement should be submitted when enrolling for electronic billing. It should be reviewed and signed **only** by the provider to ensure each is knowledgeable of the enrollment request and the associated requirements:
 - If the submitter will be submitting for multiple providers, each provider whose claim data will be submitted must complete this form.
 - The entire form must be read carefully and then dated with the day, month and year.
 - The name of the provider (an authorized officer’s name) must be printed in the space provided and that authorized officer’s title and signature must also be included.
 - When completed, all **three pages** of the properly executed **EDI enrollment agreement** must be returned **with** the EDI application form.

Providers who have contracted with a third party (clearinghouse/network service vendor or a billing agent) are required to have that third party sign an agreement in which they agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to 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 fax or hard copy of:

- Any changes in their billing agents or clearinghouses.
- The effective date they will discontinue using a specific billing agent or clearinghouse.
- If they want to begin using additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouses begin to use alternate software. The clearinghouses are 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.

The EDI Application Process

Step 1: Complete the EDI application.

Step 2: Complete and sign the Medicare Electronic Data Interchange Enrollment Agreement .The Medicare provider must complete and sign this form.

Step 3: Complete documents and fax **or** mail to the following address:

| Fax Number | MAILING ADDRESS | DELIVERY ADDRESS |
|----------------|---|--|
| (410) 683-2937 | TrailBlazer Health Enterprises, LLC EDI Department P.O. Box 4898 Timonium, MD 21094-4898 | TrailBlazer Health Enterprises, LLC EDI Department Timonium II – 6 th floor 1954 Greenspring Drive Timonium, MD 21093 |

Step 4: Retain the completed forms for your records.

Processing an EDI application will take **five business days** from the date of receipt. When processing is complete, you will receive a notification by fax or mail. New electronic submitters and software vendors will be informed of any testing requirements.

Electronic Data Interchange Application Instructions

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

The field descriptions listed below will aid in properly completing the application. Please follow these instructions closely. The Medicare Electronic Data Interchange Application is required. The Multiple Provider List should be used if you are listing additional providers on your application.

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

- Any billing agent, clearinghouse/network service vendor.
- To anyone on their staffs who has no 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 non-transferable, meaning 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.

| Form Field Name | Instructions for Field Completion |
|--|--|
| 1. Provider Data | Complete the date, provider's name, address, primary contact, phone, fax and e-mail address. <ul style="list-style-type: none"> • Check the Part A or Part B Provider indicator box. • Check the appropriate state indicator box. • Indicate the National Provider Identifier (NPI). • Action Requested: Please indicate appropriate request below: <ul style="list-style-type: none"> ○ Provider is Submitter – Provider submits claims directly from his office). ○ Provider is with billing service/clearinghouse. ○ Provider is with other providers (list provider numbers). ○ Remove provider from Submitter ID (provide Submitter ID). |
| 2. EDI Software Vendor Data | Indicate the name of the software vendor you will use for electronic claim submission to TrailBlazer. If you will use our free PC-ACE Pro32, write PC-ACE Pro32 in this field. If the vendor ID is known, enter the assigned ID; PC-ACE users may leave this field blank. |
| 3. EDI Billing Service/Clearinghouse Data | Indicate the name, primary contact, phone, fax and submitter/password of the billing service or clearinghouse that will be communicating with TrailBlazer. Do not forget to sign and date the bottom of the form. |

Medicare Electronic Data Interchange Enrollment Agreement

The undersigned provider agrees to the following provisions for submitting Medicare claims electronically to CMS or its 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) _____

Complete this form and mail or fax to:

TrailBlazer Health Enterprises, LLC
EDI
P.O. Box 4898
Timonium, MD 21094-4898
(410) 683-2937 (fax)