

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 <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:					

MEDICARE – NHIC, CORP.
ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

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

A. The Provider Agrees:

1. That it will be responsible for all Medicare claims submitted to CMS 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 contractors, 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 signature, 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 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;
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 of the provider on each claim electronically transmitted to the contractor;
10. That the CMS-assigned unique identifier number 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 contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (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 CMS contractor 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 intermediary/carrier 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 contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor 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 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 contractor 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 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 contractor. 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. (**Original signature required, PLEASE USE BLUE INK*)

Provider/Supplier Business Name _____

Address _____

City/State/Zip _____

Signature (Authorized Rep)* _____

Printed Name (Authorized Rep) _____

Title _____

Date _____

Submitter Name/Billing Agent _____

Software Vendor _____

Submitter ID _____

Vendor Phone Number _____

PIN/PTAN Number _____

NPI Number _____



**NHIC, Corp MEDICARE PART A
 EDI PROVIDER AUTHORIZATION FORM FOR THIRD-PARTY BILLING**

(This form is to be submitted by providers to authorize a third-party billing service or clearinghouse to perform EDI transactions on the provider's behalf)

I hereby request the Submitter and/or Receiver named below be allowed to perform the following functions on behalf of the provider number(s) listed below (check all that apply):

SECTION I: Select Transactions Authorized for this Submitter					
<input checked="" type="checkbox"/>	ASC X12 837 Claim V4010A1				
	ASC X12 276/277 Claim Status Inquiry & Response V4010A1				
	ASC X12 835 Electronic Remittance Advice V4010A1				
SECTION II: Submitter and/or Receiver Information					
Submitter Name			EMDEON		
Submitter ID			MAWEBMD0		
Street Address			3055 LEBANON PIKE, STE 1000		
City	NASHVILLE	State	TN	Zip Code	37214
Contact Name			ENROLLMENT HELP DESK		
Contact Phone Number			866.924.4634		
Contact Email Address			payerregistration@emdeon.com		
Operating as a: (select one)					
<input checked="" type="checkbox"/>	Clearinghouse				
	Billing Service				
SECTION III: Provider Information					
Provider Name					
Street Address					
City		State		Zip Code	
Contact Name					
Contact Phone Number					
Contact Email Address					
PTAN(s)	NPI(s)	PTAN(s)	NPI(s)		



SECTION IV: Contractor Codes (Select appropriate code)		
	14101	Maine
	14004	HHH-A
X	14201	Massachusetts
	14301	New Hampshire
	14401	Rhode Island
	14501	Vermont

Authorized Provider Signature	
Print Provider Signature	
Title	
Date	
The person signing this form understands the provider is responsible for the data submitted by the third-party submitter and received by the third-party receiver. If the data is mishandled in any way, the provider will be held responsible. The third-party is prohibited from viewing, storing, modifying, or reporting the data for their own use.	

Verify that all fields have been filled out accurately. Mistakes could delay processing significantly.

The form must be printed, signed, dated, and then faxed to:

NHIC, Corp
J14 PART A EDI ENROLLMENT
Fax Number: 781-741-3523

Forms received that are not signed, and dated will not be processed.

May 15, 2009