

PAYER ID:

SUBMITTER ID:



emdeon™

## Emdeon **Claims** 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 signatures when applicable, stamped signatures or photocopies are accepted.</li> <li><b>SUBMIT COMPLETED FORM TO:</b>            Fax: (615) 231-4843            Email: <a href="mailto:batchenrollment@Emdeon.com">batchenrollment@Emdeon.com</a></li> </ul>					
EMDEON REVISION FORM DATE:					



# ELECTRONIC DATA INTERCHANGE (EDI) SETUP REQUIREMENTS



COMPLETE ALL FIELDS. TYPE OR PRINT AND MAIL TO:

Highmark Medicare Services, Inc. - EDI, P.O. Box 890011, Camp Hill, PA 17089-0011

**CHECK ONE:**  Part A (Institutions)  Part B (Professionals)      **CHECK ONE STATE:**  DC (Part A)  DCMA (Part B)  DE  MD  NJ  PA

**A** NAME OF GROUP, PHYSICIAN, PROVIDER, OR SUPPLIER (Must match the name on file at Medicare as reported on the 855 Enrollment form for the provider number listed in Block G.) \_\_\_\_\_

**B** PRACTICE LOCATION  
 STREET ADDRESS (as reported on 855 Enrollment form) \_\_\_\_\_  
 CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

**C** CONTACT PERSON      **D** TELEPHONE NUMBER      **E** FAX NUMBER      **F** E-MAIL ADDRESS FOR LISTSERV

**G** NPI # \_\_\_\_\_ **Provider Transaction Access Number (PTAN)** \_\_\_\_\_  
 For Affiliated PTAN's, attach a signed list on company letterhead, if needed (Part A only).

**H** Please check one: (Requests will be processed as ANSI ASC X12N version 4010.A1, the HIPAA-compliant format/version.)  
 Assign this provider a new electronic billing Submitter ID.  
 Add this provider to existing Submitter ID 1924804 PRJ 46Y7

**I** PLEASE CHECK MODEM PROTOCOL:  HAYES/Z-Modem (Default option if PC-ACE Pro32 or blank.)  MNP

**J** COMPLETE THE VENDOR, BILLING SERVICE, AND/OR CLEARINGHOUSE INFORMATION:  
 PC-ACE Pro32 (only check if enrolling for the Medicare-issued software. If enrolling for PC-ACE Pro32 the PC-ACE Pro32 Agreement form (8287) is required.)  
 Name of software vendor: \_\_\_\_\_  
 Name of billing service: \_\_\_\_\_  
 Name of clearinghouse: Emdeon

**K** PLEASE READ CAREFULLY AND COMPLETE, AS APPROPRIATE  
**If the provider number listed in Block G is associated to any other submitter number(s), Medicare will remove the other submitter number(s) before assigning a new submitter number.** The following information is for **Part B ONLY**: If a provider is associated to a submitter number, the provider can maintain the submitter number for 45 days by including a signed, written letter requesting to keep the submitter number for 45 days. After 45 days, Medicare will remove the submitter number from the provider without notice. Multiple submitter numbers are not permitted after the initial 45-day time period. If you want to receive or continue receiving ERA, you also need to complete the Electronic Remittance Advice (ERA) Enrollment form (8262).

**L** Read, Complete and Sign: (Please print or type in blue or black ink)  
 Any provider enrolling to submit Medicare claims, electronically to CMS or its contractors remains responsible for those claims as those responsibilities are outlined on the Electronic Data Interchange Agreement form (8275). In accepting claims submitted electronically to the Medicare Program from any billing service or through the use of a particular product which accomplishes this process, neither CMS, Highmark Medicare Services, Inc. nor any other Medicare contractor is attesting to the appropriateness of the methods used by the billing service/clearinghouse or to the accuracy of a particular vendor's product which purportedly facilitates such electronic submissions. The provider furnishing the item or service for whom payment is claimed under the Medicare Program retains the responsibility for any claim regardless of the format in which it chooses to submit the claim.  
 Any provider that contracts to submit/receive transactions electronically using a billing agent or a clearinghouse/network service vendor, carriers, DMERC's, FIs or any other contractors as designated by CMS must have an agreement signed by that third party indicating 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. Providers are not permitted to share their personal EDI access number and password with any billing agent, clearinghouse/network service vendor; with 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; with any other non-staff individuals or entities. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. Medicare reserves the right to terminate this arrangement if there is no EDI activity within a six (6) month period.  
 I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions contained within the Electronic Data Interchange Agreement form (8275) and acknowledge same by signing below. An authorized official is an appointed official to whom the supplier has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the supplier's status in the Medicare Program (e.g., new practice locations, change of address, etc.), and to commit the supplier to fully abide by the laws, regulations, and the program instructions of Medicare. **The authorized official must be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of five percent or more of the supplier (see Section 5 of the 855 Enrollment Form for a definition of "direct owner"), or must hold a position of similar status and authority within the supplier's organization.**  
 I understand that any individual who knowingly and willfully makes or causes to be made any false claim or false statement or false statement or false representation of a material fact in any application to the federal government for benefits or payment with respect to the Medicare program may be subject to civil and/or criminal enforcement action which may result in fines, penalties, damages and/or imprisonment.  
 I certify that I have been appointed an authorized official of the indicated party as general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of five percent or more of the supplier, or holder of a position of similar legal status and authority within the supplier's organization.

<b>AUTHORIZED OFFICIAL:</b> Original Signature	Printed Name	Title	Date Signed

## ELECTRONIC DATA INTERCHANGE (EDI) AGREEMENT

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS's carriers, MACs, or FIs .

**A. The Provider Agrees:**

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contractor 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, MACs, 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, and procedure/service performed.
5. That the Secretary of Health and Human Services or his/her designee and/or the carrier, MAC, FI, 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 carrier, MAC, FI, or other contractor if 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, MAC, FI or other contractor if designated by CMS, shall not be used by agents, officers, or employees of the billing service except as provided by the carrier, MAC, or FI (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, MAC, FI or other contractor 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 (CMS) will:**

1. Transmit to the provider an acknowledgement of claim receipt.
2. Affix the fiscal intermediary/carrier/MAC 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, MAC, FI or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, DMERC or FI or from any subsidiary of the carrier, MAC, FI or other contractor if designated CMS or from any company for which the carrier, MAC or FI has an interest. The carrier, MAC, 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 carriers, MACs, FIs, or another contractor if so 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, MAC, 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 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 the carrier, MAC, 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.

**REQUESTS TO BECOME AN EDI BILLER MUST ALSO  
INCLUDE THE EDI SETUP REQUIREMENTS FORM 8276**

**Complete and Sign back of form & Return to:**

**Highmark Medicare Services, Inc. - EDI,  
P.O. Box 890011, Camp Hill, PA 17089-0011**

## ELECTRONIC DATA INTERCHANGE (EDI) AGREEMENT

**C. Read, complete, and sign: (Please print or type in blue or black ink)**

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PTAN (Medicare Provider Transaction Access Number)	NPI Number
Name of Group, Physician, Provider, or Supplier as reported on 855 Enrollment form	
Practice Location Address of Group, Physician, Provider, or Supplier ( <i>street</i> )	
Practice Location Address of Group, Physician, Provider, or Supplier ( <i>city, state, zip</i> )	
Authorized Signature	Date
Printed Name of Authorized Signature	Title