

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:					
PROVIDERS MUST SUBMIT ENROLLMENT FORM DIRECT TO THE PAYER FAX FORM TO; Cahaba Home Health (205) 733-7202					
STATES INCLUDED: (CO , KS , MD , MO , MT , ND , NE , PA , VA , WV , & WY)					
EMDEON REVISION FORM DATE:					

EDI Services Home Health & Hospice Enrollment Application



Instructions: This is for new submitters/providers only. It is very important that you answer each question accurately including only requesting services and products that you truly need to conduct business with Cahaba GBA EDI Services. Fax completed form(s) to the fax number below.

I submit Medicare home health and/or hospice claims to Cahaba GBA's office in:

- Des Moines, Iowa – Fax form to (205) 733-7202
For EDI support call (866) 839-2441

I am a:

- Medicare home health / hospice Provider Vendor/Clearinghouse/Billing Service

I. FACILITY INFORMATION or VENDOR/CLEARINGHOUSE/BILLING SERVICE INFORMATION

Any information that we have on file will be updated with what you provide below.

1. List your Medicare provider number(s) _____

If you need more space, please attach on a separate sheet

List your National Provider Identifier (NPI): _____

Facility Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____

Telephone: (_____) _____ Fax: (_____) _____

E-Mail: _____

Please be sure that you are signed up for EDI News through our [E-mail Notification Service](#).

II. DATA INTERCHANGE INFORMATION - CLAIMS

1. Will you transmit batched claim files to Cahaba GBA directly? Yes No
If you answered "No" please skip to question number 4 below.

2. Will you be using software from a vendor? Yes No
If you answered "Yes" please complete the following:

Vendor Name: _____

Software name and version: _____

Address: _____

City: _____ State: _____ Zip: _____

Vendor Contact: _____ Contact Telephone: (_____) _____

Please Note: Check [EDI Services Testing Procedures](#) to determine your need to test.

3. If you will not be using a vendor's software product, will you be using PC-Ace Pro32 Medicare freeware? Yes No

Please Note: If you are using a billing service or clearinghouse to conduct any Medicare business on your behalf, you must have 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. It is not required to submit such an agreement to Cahaba GBA, but the provider is required to retain the agreement.

4. Will you be using a billing service or a clearinghouse to submit your claims on your behalf? Yes No
If you answered "Yes", please complete the following:

Billing Service/Clearinghouse Name: EMDEON

Address: 26 CENTURY BLVD STE 2000

City: NASHVILLE State: TN Zip: 37214

Contact Name: ENROLLMENT HELPDESK Contact Telephone: (866) 924.4634

If this entity currently submits claims to Cahaba GBA, please provide their submitter ID number: IA001618

5. Will this billing service/clearinghouse be performing the following services on your behalf with Cahaba GBA? (check all that apply)

- Submitting claims electronically via Direct Data Entry (DDE).
 Correcting claims online in FISS.
 Verifying patient eligibility.
 Verifying claim status.

If you have selected any options from this list, you must authorize the 3rd party listed in Section II.4 to access FISS. I authorize _____ FISS access for the provider numbers listed above.

Enter name of 3rd Party

6. If you will need access to FISS you must complete and submit a System Access Request form along with this application.

III. DATA INTERCHANGE INFORMATION – REMITTANCE ADVICE

1. If you are a Medicare provider, indicate below how you will receive your electronic remittance advice (ERA).

Choose one:

- I would like my ERAs to be delivered to my FTP directory.
 I would like my ERAs to be delivered to my billing service/clearinghouse's FTP directory.

Billing Service/Clearinghouse Name: EMDEON

Address: 26 CENTURY BLVD STE 2000

City: NASHVILLE State: TN Zip: 37214

Billing service/clearinghouse's Cahaba GBA submitter ID number: _____

Contact Name: ENROLLMENT HELPDESK Contact Telephone: (866) 924.4634

Please note: ERAs can only be received by one submitter ID for a given provider number.

2. Will you be using PCPrint Medicare freeware to view and print your ERAs? Yes No

IV. CONNECTIVITY INFORMATION

1. You must use a CMS approved connectivity vendor (such as Visionshare or IVANS) for DDE access to FISS or ELGA/ELGH

Connectivity Vendor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Contact Telephone: (____) _____

2. Are you interested in a Frame Relay connection to Cahaba GBA? Yes No

To learn more about what Frame Relay is please refer to the "[Electronic Billing With Cahaba GBA Booklet](#)"

If you do not use a connectivity vendor for your FTP processes, you will need to connect to Cahaba GBA via dial-up connection for your FTP processes. You will need to complete and submit a System Access Request with this enrollment form so that we can establish secure IDs and passwords for you.

IV. Electronic Agreement To Be Reviewed and Signed By Medicare Provider

The following section must be read and signed by an authorized representative for the Medicare provider.

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers, DMERCs, or FIs:

1. That it will be responsible for all Medicare claims submitted to Cahaba GBA 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, *DMERCs*, *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, DMERC, 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 six years, three 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, DMERC, 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, DMERC, 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, DMERC, or FI (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 carrier, DMERC, FI, or other contractor if designated by CMS within two business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services (CMS) agrees to:

1. Transmit to the provider an acknowledgment 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' 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, or FI or from any subsidiary of the carrier, DMERC, FI, 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 carriers, DMERC, FIs, or other contractors 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, or indirectly, or by arrangement;
6. Notify the provider within two business days if any transmitted data are received in an unintelligible or garbled form.

NOTE: 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, DMERC, FI, or other contractor if designated by CMS. 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.

Printed Name: _____

Official Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Send all four pages of this completed EDI Enrollment Form/Agreement and completed *System Access Request* form via fax to the fax number listed at the top of this form.



EDI Services Part A Enrollment Update Application



Instructions: This is for existing submitters and providers enrolled in EDI, only. It is very important that you answer each question accurately including only requesting services and products that you truly need to conduct business with Cahaba GBA EDI Services. Fax completed form(s) to the fax number below.

I submit Medicare Part A claims to Cahaba GBA's office in:

Des Moines, Iowa – Fax form to (205) 733-7202

For EDI support call (866) 839-2441

I am a:

Medicare Part A Provider Vendor/Clearinghouse/Billing Service

- If you are updating your facility's contact information only, complete sections I and V.*
- If you are reporting a change in vendor, clearinghouse or billing service complete sections I, II and V.*
- If you are making changes to your method of connectivity, complete sections I, IV and V.*
- If you are making changes to your remittance advice, complete sections I, III and V.*

I. FACILITY INFORMATION or VENDOR/CLEARINGHOUSE/BILLING SERVICE INFORMATION

section I.1 required for all requests

Any information that we have on file will be updated with what you provide below.

1. List your Cahaba GBA Submitter ID number _____

Facility Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____

Telephone: (____) _____ Fax: (____) _____

E-Mail: _____

Please be sure that you are signed up for EDI News from our list serv at www.cahabagba.com

2. List any changes to your Medicare Provider Number(s):

Additions: _____

Deletions: _____

List unchanged Provider number(s): _____

If you need more space, please attach on a separate sheet of paper

List your National Provider Identifier (NPI): _____

II. DATA INTERCHANGE INFORMATION - CLAIMS

1. How do you currently submit your claims to Cahaba GBA?

- I transmit batched claim files to Cahaba GBA directly
- I use a clearinghouse or billing service that transmits my batched claim files.
- I key my claims online using Direct Data Entry (DDE).

2. If you will be using software from a vendor, please complete the following:

Is this information being updated? Yes No

Vendor Name: _____

Software name and version: _____

Address: _____

City: _____ State: _____ Zip: _____

Vendor Contact: _____ Contact Telephone: (____) _____



3. If you will not be using a vendor's software product, will you be using PC-Ace Pro32 Medicare freeware? Yes No

Please Note: If you are using a billing service or clearinghouse to conduct any Medicare business on your behalf, you must have 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. It is not required to submit such an agreement to Cahaba GBA, but the provider is required to retain the agreement.

4. If you will be using a billing service or a clearinghouse to submit your claims on your behalf, please complete the following:

Is this information being updated? Yes No Date Change(s) to take effect: _____

Former Billing Service/Clearinghouse Name: _____

New Billing Service/Clearinghouse Name: EMDEON

Address: 26 CENTURY BLVD STE 2000

City: NASHVILLE State: TN Zip 37214

Contact Name: ENROLLMENT HELP DESK Contact Telephone: (866) 924.4634

If this entity currently submits claims to Cahaba GBA, please provide their submitter ID number: IA001618

5. What services will this vendor perform on your behalf with Cahaba GBA? (check all that apply)

- Submitting claims electronically via batch claim file.
- Submitting claims electronically via Direct Data Entry.
- Retrieving my Electronic Remittance Advice statements.
- Correcting claims online in FISS.
- Verifying patient eligibility.
- Verifying claim status.

6. If you are making changes to your access to the FISS claim processing system for the purpose of online access to eligibility, claims status or correction of claims (DDE), please complete the following:

Do you have DDE access you need to terminate? Yes No

If you answered "Yes" you will need to also submit a System Access Change Request with this Change Enrollment form.

Do you need DDE access that you do not currently have? Yes No

If you answered "Yes" you will need to also submit a System Access Request with this Change Enrollment form.

III. DATA INTERCHANGE INFORMATION – REMITTANCE ADVICE

1. If you are a Medicare provider; needing to make changes to the way you receive your remittance advice statements, please complete the following:

Do you currently receive your remittance advice electronically? Yes No

If you answered "No", do you want to begin receiving your remittance advice electronically? Yes

If you answered "Yes", please provide the submitter ID number that you want to receive your ERA file:

If this submitter ID is assigned to a 3rd Party, you must also complete section II.4 and 5.

Please note: ERAs can only be received by one submitter ID for a given provider number.

2. Will you be using PCPrint Medicare freeware to view and print your ERAs? Yes No

IV. CONNECTIVITY INFORMATION

1. How do you currently connect to Cahaba GBA?

- I use a dial-up connection with my PC.
- I have a frame relay connection with Cahaba GBA.
- I use a connectivity vendor (such as Visionshare or IVANS).

2. How will you be connecting to Cahaba GBA?

- I will use a dial-up connection with my PC.
- I would like to establish a frame relay connection with Cahaba GBA.
- I will be using a connectivity vendor (such as Visionshare or IVANS)

If you checked the last box, please complete the following:

Connectivity Vendor Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact Name: _____ Contact Telephone: (____) _____

V. AUTHORIZED SIGNATURE

I am authorized to sign this document on behalf of the indicated party and to request the changes indicated in this document. *Changes will not be made without an authorized signature.*

Printed Name: _____

Official Title: _____

Address: _____

City: _____ State: _____ Zip: _____

Signature: _____ Date: _____

Date change(s) to take effect. (must match date in II.4) _____