

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>SUBMIT COMPLETED FORM TO:            Fax: (615) 231-4843            Email: <a href="mailto:batchenrollment@Emdeon.com">batchenrollment@Emdeon.com</a></li> </ul>					
EMDEON REVISION FORM DATE:					

## P B S I E D I A G R E E M E N T

Below is the EDI Agreement, which is a required component of the entire enrollment packet for a provider submitting claims electronically, as stipulated by the Centers for Medicare and Medicaid Services.

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

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	Diagnosis/nature of illness
Beneficiary's health insurance claim number	Procedure/service Performed
Date(s) of service	

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 (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) or NPI 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 within two business days if any transmitted data are received in an unintelligible or garbled form.

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

1. Transmit to the Provider an acknowledgement of claim receipt.
2. Affix the carrier, MAC, FI 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, MAC, FI or other contractor if designated by CMS may require the Provider to purchase any or all electronic services from the carrier, MAC, or FI or from any subsidiary of the carrier, MAC, FI, or other contractor if designated by CMS or from any company for which the carrier, MAC, or FI has an interest. The carrier, MAC, FI or other contractor 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, MAC, FI or other contractor is 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 is designated by CMS sells directly, indirectly, or by arrangement.
6. Notify the Provider within two 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 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.



**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.

<b>Provider/Facility Name</b>	<b>Provider's Submitter #</b> <i>(If currently set up with EDI and making changes)</i>
<b>Provider's Signature</b> <i>(must be signed by the Provider, Clinic Administrator or Hospital Administrator)</i>	<b>Title</b>
<b>Printed Name of the Above Signer</b>	<b>Date</b>
<b>Group/ Pay-to NPI #</b>	<b>Group PTAN/ Pay-to Provider #</b>
<b>Provider's TAX ID #</b>	<b>Contact Person(s)</b>
<b>Phone #</b>	<b>Fax #</b>
<b>Phone #</b>	<b>Email</b>

**Check only one state:**  
 Louisiana  Arkansas

**If Arkansas, indicate line of business:**  
 Medicare Part A  Medicare Part B

All new EDI Submitters effective 03/01/09 will be set up with Electronic Remittance Advices (ERA) automatically. If a provider is using a clearinghouse for claims, PBSI, by default will return the ERA to that clearinghouse's mailbox. For more information please go to <http://www.arkmedicare.com/provider/viewarticle.aspx?articleid=7748> or <http://www.lamedicare.com/provider/viewarticle.aspx?articleid=7748>

**Requesting batch 276/277 Claim Status Request and Response.** Indicate the Submitter # sending 276/277 transactions: \_\_\_\_\_  
 (Before requesting, please verify that your software vendor and/or practice management software can generate and produce this transaction)

**837 CLAIMS TRANSMISSION INFORMATION: (ONLY CHECK ONE BOX)**

**By checking this box, you are authorizing a Third Party/Clearinghouse/Billing Agency to send on your behalf.**

\*\*\*\*\*Please supply the complete name and Submitter Number of the Clearinghouse/Billing Agency\*\*\*\*\*

**Name:** EMDEON **Submitter Number:** L0753

**I will be sending directly from my facility using dial up Gateway**  **or dial up FTP**  **(requires proprietary commands See our User Guide for details)**

\*\*\*\*If you are a new direct submitter you will need to complete your vendor information below or provide the Vendor Code\*\*\*\*

<b>Software Vendor Name</b>	<b>Vendor Code</b> <i>(contact your software vendor for their Vendor Code)</i>
<b>Address</b>	<b>City, State, Zip</b>
<b>Contact (printed Name)</b>	<b>Contact Email</b>
<b>Contact Phone # (include extension)</b>	<b>Contact Fax #</b>

Please fax, mail, or email this completed agreement to the address or fax number below. To check on enrollment status you can email us at [edi\\_enrollment@arkbluecross.com](mailto:edi_enrollment@arkbluecross.com). Please allow 7 business days before asking for enrollment status.

**RETURN ADDRESS:**  
**EDI Services -4BC/S**  
**PO Box 2181 Little Rock, AR 72203-2181**  
**FedEx or UPS: 601 S. Gaines St. Little Rock, AR 72201**  
**Service Line (501) 378-2419 Toll Free (866) 582-3247 Fax (501) 378-2265**  
**Email: [edi\\_enrollment@arkbluecross.com](mailto:edi_enrollment@arkbluecross.com)**