



P.O. Box 7011 Northridge, Ca 91327-7011 \* (818) 368-5501 \* [www.signatureclaims.net](http://www.signatureclaims.net)

## Provider Sign-up Form Information

Georgia Medicare

Fill in all information in Sections B through J

In Section L check 835 ERA ONLY if you want the electronic ERA. NOTE:  
This will usually STOP your paper EOBs.

Sign page 1 and page 2.

This form can be mailed or faxed to:

Cahaba GBA, LLC  
EDI Services  
PO Box 3018  
Savannah, GA 31402-3018  
~~FAX: 205 220 9116~~  
FAX: 205 402 9200



## ELECTRONIC DATA INTERCHANGE (EDI) APPLICATION

<b>A</b> SELECT STATE (Select One)		
<input type="checkbox"/> ALABAMA <input checked="" type="checkbox"/> GEORGIA <input type="checkbox"/> MISSISSIPPI		
<b>B</b> NAME OF GROUP, PHYSICIAN, OR FACILITY		
<b>C</b> MAILING ADDRESS		
ADDRESS _____		
CITY _____ STATE _____ ZIP CODE _____		
<b>D</b> CONTACT PERSON		<b>E</b> TELEPHONE NUMBER
<b>F</b> FAX NUMBER	<b>G</b> E-MAIL ADDRESS	
<b>H</b> MEDICARE GROUP OR PROVIDER NUMBER	<b>I</b> NATIONAL PROVIDER IDENTIFIER	<b>J</b> FEDERAL ID TAX NUMBER
<b>K</b> SOFTWARE VENDOR, BILLING SERVICE, OR CLEARINGHOUSE INFORMATION		
REQUESTING MEDICARE'S FREE PC-ACE PRO32 SOFTWARE (If yes, go to section <b>L</b> ) <input type="checkbox"/> YES <input type="checkbox"/> NO		
METHOD OF DATA INTERCHANGE (Select one) <input type="checkbox"/> SOFTWARE VENDOR (DIRECT) <input checked="" type="checkbox"/> BS/CLEARINGHOUSE (3 <sup>rd</sup> PARTY)		
NAME _Signature Claims_____ PHONE NUMBER _(818) 368-5501_____		
STREET ADDRESS _PO Box 7011_____		
CITY _Northridge_____ STATE _CA_____ ZIP CODE _91327-7011_____		
SUBMITTER ID (If known) __GAF02-801_____		
<b>L</b> REQUESTING ELECTRONIC REMITTANCE ADVICE (See important note concerning ERA located on instruction page.)		
<input type="checkbox"/> YES <input type="checkbox"/> NO		

**M** If the method of data interchange selected above is billing service or clearinghouse, you authorize the entity listed in section **K** to conduct electronic transactions on your behalf. A provider may not authorize submission or receipt of Medicare beneficiary information by a third party unless that beneficiary is a current patient of the provider, has scheduled an appointment, or has inquired about the receipt of supplies or services from the provider.

I have read and agree to the above statements and foregoing provisions contained within the attached EDI Enrollment Form.

Authorized Signature	Printed Name
Title	Date

**EDI ENROLLMENT FORM MUST BE SUBMITTED WITH THIS APPLICATION**

## Electronic Data Interchange (EDI) Enrollment Form

**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 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, 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.

_____ Provider's Name (Print)
_____ Title (Print)
_____ Address (Print)
_____ City/State/Zip Code (Print)
_____ By (Provider's Signature)
_____ Title (Print)
_____ Date

***\*This agreement must be signed by the provider or an employee of the provider. It may not be signed by a representative of the provider's billing service or clearing house.***

## EDI APPLICATION & ENROLLMENT FORM

SECTION	INSTRUCTIONS
<b>A</b>	Select the state in which the provider renders services. If you wish to enroll for EDI in multiple states, you must complete separate applications.
<b>B</b>	Type or print the name of the group, physician, or facility enrolling for Electronic Data Interchange (EDI). The name listed must match the name on file at Medicare for the Medicare number listed in block H.
<b>C</b>	Type or print the mailing address, including suite/building numbers, of the group, physician, or facility enrolling for EDI.
<b>D</b>	Type or print a contact person in your office who has the knowledge and authority to answer questions regarding your enrollment.
<b>E</b>	Type or print the telephone number, including area code, of the contact person listed in block D.
<b>F</b>	Type or print the FAX number, including area code, for the group, physician, or facility enrolling for EDI.
<b>G</b>	Type or print the office internet e-mail address for the group, physician, or facility enrolling for EDI.
<b>H</b>	Type or print the Medicare group, physician, or facility number enrolling for EDI. If you are a group practice, each provider associated with your group will be enrolled automatically. You <b>do not</b> need to send in a separate application for each member of your group or when adding providers to your practice.
<b>I</b>	Type or print the national provider identifier (NPI #) enrolling for EDI (if available).
<b>J</b>	Type or print the group, physician, or facility's EIN or Federal Tax ID number enrolling for EDI.
<b>K</b>	Indicate if you wish to receive Medicare's free billing/ERA software PC-ACE Pro 32. If yes, then skip remaining fields in section K and go to section L. Otherwise, type or print the name, complete address, and phone number of your vendor, billing service, or clearinghouse.
<b>L</b>	Indicate if you wish to enroll for electronic remittance advice (ERA). Please note: If you enroll for ERA, your paper remittance will stop 45 days after enrollment. Ask your software vendor, billing service, or clearinghouse if they support ERA before enrolling.
<b>M</b>	After reading the enrollment form, complete and sign the application. This must be signed by an authorized individual of the group, physician, or the facility. It may not be signed by a representative of the provider's billing service or clearinghouse.

### Types of Vendors:

**Billing Service** - A billing service is an entity that markets claim preparation services to providers and may also be able to perform related transactions for providers, such as eligibility and claim status inquiries. The billing service collects a provider's claim information and then bills the appropriate insurance companies, including Medicare. A billing service may submit claims only, or provide full financial accounting and/or other services. Billing services are considered to be provider business associates. As such, HIPAA requires that they comply with each of the privacy and security requirements that apply directly to providers. They are also required to ensure that they require that any clearinghouses, subcontractors or other business associates of their own that may be involved with handling of Medicare beneficiary data also meet those same security and privacy requirements.

**Clearinghouse** - A clearinghouse transfers or moves EDI transactions for a provider or billing service, and generally translates the EDI transactions from or into a proprietary format. (HIPAA defines a clearinghouse as a business associate of a provider or a health care plan that translates data from a non-standard format into a standard format or vice versa as preferred by their clients.) A clearinghouse generally accepts multiple types of incoming transactions and sends them to various payers, including Medicare. Clearinghouses often perform general and payer-specific edits on claims, and may handle multiple types of EDI transactions for a given provider. Clearinghouses frequently reformat data for various payers, and manage acknowledgements, remittance advice transactions, and claim status and eligibility queries.

**Software Vendor** - A software vendor is an entity that markets practice management software to healthcare providers. The software may provide a variety of functions including scheduling, billing, accounts receivable, accounts payable, insurance claims submission, electronic remittance advice processing and electronic health records to name a few.

### Mail or FAX the completed EDI Enrollment Forms to:

#### Alabama/Mississippi

Cahaba GBA, LLC  
EDI Services  
PO Box 12566  
Birmingham, AL 32502-2566  
FAX: 205 220-9116

#### Georgia

Cahaba GBA, LLC  
EDI Services  
PO Box 3018  
Savannah, GA 31402-3018  
FAX: 205 220-9116