



P.O. Box 7011 Northridge, Ca 91327-7011 * (818) 368-5501 * www.signatureclaims.net

Provider Sign-up Form Information
Southern California, Nevada, Hawaii, Guam,
American Somoa and Northern Mariana Islands

Mail or fax this form to:

Palmetto GBA
Jurisdiction 1, AG-420
PO Box 100145
Columbia SC 29202-3145

J1 EDI Application Form Instructions

The purpose of the **J1 EDI Application Form** is to enroll providers, software vendors, clearinghouses and billing services as electronic submitters and recipients of electronic claims data. **It is important that instructions are followed and that all required information is completed. Incomplete forms will be returned to the applicant, thus delaying processing.**

Please retain a copy of this completed form for your records.
You must submit a completed EDI Application Form when submitting additional EDI forms.

The field descriptions listed below will aid in completing the form properly. There are two (2) pages to the application form. The first page is required and the second page should be used only if additional providers need to be listed.

Form Field Name	Instructions for Field Completion
Line of Business Information:	Indicate the line of business and states for which you will be transmitting. Select all that apply to this request.
Action Requested: Add Provider(s) Change/Update Delete Apply for New Submitter ID Apply for PS&R ID	Indicate the action to be taken on the application form. <ul style="list-style-type: none"> • If you need to add additional providers to an existing submitter ID, check Add Provider(s). • If you request to change or update information about the Submitter and/or Provider, check Change/Update and be sure to include your current Submitter ID. • If you request to delete a provider(s), check Delete and be sure to include your submitter ID. • If you are a new applicant, check Apply for New Submitter ID. • If you are applying for a Part A Provider Statistical and Reimbursement (PS&R) ID, check Apply for PS&R.
Submitter ID:	The submitter ID is used by the submitter to communicate with Palmetto GBA electronically. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID. For changes or additions, enter the Submitter ID to which the change/additions should be applied. Submitters who have a PS&R and/or DDE submitter ID should also enter it in the spaces provided.
Date:	Please enter the date the application is completed.
PPTN ID:	The PPTN ID is used by the submitter to directly access our Part B claim status inquiry system. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID. For requests to Add Provider(s) or make a Change , please enter your existing PPTN ID.
DDE ID:	The DDE User ID is used by the submitter to directly access our Part A claims processing system. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID, if requested. For requests to Add Provider(s) or make a Change , please enter your existing DDE ID.
PS&R ID:	The PS&R ID is used by the submitter to access our GPNet to download Part A PS&R reports. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID. Note: PS&R reports are only available through GPNet.
Submitter Name:	Enter the name of the entity (provider, software vendor, billing service or clearinghouse) that will actually be communicating electronically with Palmetto GBA.
Type of Submitter:	Check the appropriate box.
Contact Person:	The name of the submitter's primary EDI contact. This is the person Palmetto GBA will contact if there are questions regarding the application or future questions about their communications.

J1 EDI Application Form

This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS) and American National Standard Institute (ANSI). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

Form Field Name	Instructions for Field Completion
Phone:	The area code and phone number of the Contact Person listed.
FAX:	The FAX number for this location.
Address:	The mailing address of the submitter.
City, State, Zip:	The city, state and zip code of the submitter.
Submitter E-mail Address:	The e-mail address of the contact person listed. Note: This will be the primary method of communication. This e-mail address will also receive EDI Tracking Numbers used to monitor the processing status of your EDI forms.
Claim Submission Mode of Communication:	There are four available modes of communication modes that can be used for claim submission. Check only one . <ul style="list-style-type: none"> • GPNet: Asynchronous communication with the Gateway • Connect Direct – NDM: Network Data Mover • Dial-up FTP: File transfer protocol transmission via GPNet – not Internet. • Leased FTP: File transfer protocol transmission via the Internet or Network-based connection.
Report / Electronic Remittance Retrieval Mode of Communication:	Check only one mode of communication that will be used. <ul style="list-style-type: none"> • GPNet Asynchronous should be checked for asynchronous communication with Palmetto GBA’s GPNet. • CONNECT:Direct (NDM) should be checked for report retrieval via GPNet • Dial-up FTP should be checked for file transfer protocol report retrieval via GPNet. • Leased FTP: File transfer protocol transmission via the Internet or Network-based connection.
Report Response Format:	Check the format in which you will receive GPNet Claims Acceptance Responses.
Data Compression:	To receive files compressed for faster transmission, indicate which data compression utility you support.
PS&R Mode of Communication	The only mode of communication available to J1 Part A providers for PS&R retrieval is through GPNet Asynchronous .
Name of Software Vendor	Indicate the name of the software vendor you are using, if applicable.
Vendor ID:	Include Vendor ID number if known.
Name of Online Inquiry Services Connectivity Vendor:	If applicable Indicate the name of the Online Inquiry Services Connectivity Vendor you are using or plan to use for access to Direct Data Entry (DDE) or Professional Provider Telecommunications Network (PPTN).
Providers For Whom Submitter Will Be Communicating Electronically:	
Provider Name:	List each provider whose bills will be submitted by the submitter named above. (If additional providers need to be listed, indicate each one separately on the <i>Multiple Providers List</i> form.)
Provider E-mail address:	Indicate the e-mail address for the provider listed above. This e-mail address will be the primary source of communications regarding approval of changes to their EDI options.
Provider Number:	Indicate the Medicare Provider Number for each provider listed.
NPI:	Include the National Provider Identifier (NPI).
Enrollment Form Attached: Y/N	Indicate “Y” for Yes or “N” for No. A properly executed 3-page EDI Enrollment Agreement must be attached for <i>each</i> provider listed. Palmetto GBA will not activate a submitter ID for any provider without a properly executed enrollment form.
Submit Claims:	Check this box if the application is for the submitter to submit claims electronically for this provider.
Receive Reports:	Check this box if the submitter wants to receive response reports electronically for the provider indicated.

Form Field Name	Instructions for Field Completion
Receive Electronic Remittances:	Check this box if the submitter wants to receive Electronic Remittances for the provider indicated. Provider must be submitting claims electronically to receive Electronic Remittances.
Online Inquiry:	Check this box if the submitter currently uses or plans to use the Online Inquiry Services (DDE or PPTN).

Once you have completed the application form, please retain a copy for your records and mail the original to the address listed below. Your Submitter ID and software (if applicable) will be processed within 20 business days of receipt of completed forms. Submit completed form to:

Palmetto GBA
 Jurisdiction 1, AG-420
 PO Box 100145
 Columbia SC 29202-3145



**Jurisdiction 1
Electronic Data Interchange Application**

Line of Business Information: Part A Part B

CA NV HI (Note: Includes Samoa, Guam and Northern Mariana Islands)

Action Requested: Add Provider(s) Change / Update Delete
 Apply for New Submitter ID Apply for PS&R ID

Submitter ID (if available): _____ Date: _____

PPTN ID: _____ DDE ID: _____ PS&R ID: _____

Submitter Name: _____

Type of Submitter: Software Vendor Billing Service Provider Clearinghouse

Contact Person: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ ZIP: _____

Submitter E-mail Address: _____

Note: E-mail will be the primary method of communication.

Claim Submission Mode of Communication:	<input type="checkbox"/> GPNet Asynchronous <input type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Dial-up FTP <input type="checkbox"/> Leased FTP
Report / Electronic Remittance Retrieval Mode of Communication:	<input type="checkbox"/> GPNet Asynchronous <input type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Dial-up FTP <input type="checkbox"/> Leased FTP
Report Response Format:	<input type="checkbox"/> File	<input type="checkbox"/> Report
Data Compression:	<input type="checkbox"/> Uncompressed (GPNet Default) <input type="checkbox"/> PKZIP	<input type="checkbox"/> UNIX-Compress
PS&R Mode of Communication:	<input checked="" type="checkbox"/> GPNet Asynchronous	
Name of Software Vendor:	Vendor Security ID:	
Online Inquiry Connectivity Vendor:	<input type="checkbox"/> IVANS <input type="checkbox"/> VisionShare <input type="checkbox"/> Other:	

Providers for Whom Submitter Will Be Transmitting:

Provider Name: _____

Provider E-mail Address: _____

Provider Number: _____ NPI: _____

Enrollment Form Attached? Yes No

Submit Claims Receive Reports Receive Electronic Remittances Online Inquiry Services

Submit completed form to: **Palmetto GBA** **Please retain a copy for your records.**
 Jurisdiction 1, AG-420
 PO Box 100145
 Columbia SC 29202-3145

Please retain a copy for your records. You must submit a completed EDI Application Form when submitting additional EDI forms.

J1 EDI Application Form



Jurisdiction 1 Electronic Data Interchange Application

Multiple Providers List

Date: _____

PROVIDERS FOR WHOM SUBMITTER WILL BE TRANSMITTING:

Provider Name: _____

Provider E-mail Address: _____

Provider Number: _____ NPI: _____

Enrollment Form Attached? Yes No

Submit Claims Receive Reports Receive Electronic Remittances Online Inquiry Services

Provider Name: _____

Provider E-mail Address: _____

Provider Number: _____ NPI: _____

Enrollment Form Attached? Yes No

Submit Claims Receive Reports Receive Electronic Remittances Online Inquiry Services

Provider Name: _____

Provider E-mail Address: _____

Provider Number: _____ NPI: _____

Enrollment Form Attached? Yes No

Submit Claims Receive Reports Receive Electronic Remittances Online Inquiry Services

Provider Name: _____

Provider E-mail Address: _____

Provider Number: _____ NPI: _____

Enrollment Form Attached? Yes No

Submit Claims Receive Reports Receive Electronic Remittances Online Inquiry Services

Please mail this form to: **Palmetto GBA**
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Please retain a copy for your records.



EDI Enrollment (Agreement) Form and Instructions

The EDI Enrollment Form (commonly referred to as the EDI Agreement) should be submitted when enrolling for electronic billing. It should be reviewed and signed **only** by the providers to ensure each provider is knowledgeable of the enrollment request and the associated requirements.

Providers that have contracted with a third party (clearinghouse/network service vendor or a billing agent) are required to have an agreement signed by that 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 the viewing or use of Medicare Beneficiary data. These agreements are not to be submitted to Medicare, but are to be retained by the providers.

Providers are obligated to notify Medicare by letter of:

- Any changes in their billing agent or clearinghouse.
- The effective date of which the provider will discontinue using a specific billing agent or clearinghouse.
- If the provider wants to begin to use additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouse begins to use alternate software, the clearinghouse is responsible for notification in this instance.

Note: The binding information in an EDI Enrollment Form does not expire if the person who signed the form for a provider is no longer employed by the provider.

General Instructions:

- Please ensure that you include your **Medicare Provider Number** and **National Provider Identifier [NPI]** where requested on the EDI Enrollment Form.
- If the submitter will be submitting for multiple providers, this form must be completed by *each* provider whose claim data will be submitted.
- The entire form must be read carefully, dated with day, month and year.
- The name of the provider must be printed in the space provided, an authorized officer's name (printed), authorized officer's title and signature.
- When completed, the properly executed **3-page EDI Enrollment Form** must be returned *with* the **EDI Application** form to the following address:

Palmetto GBA
Jurisdiction 1, AG-420
PO Box 100145
Columbia, SC 29202-3145

Note: If the submitter will be an entity other than the provider, the submitter must complete the EDI Application form and the provider(s) must complete the EDI Enrollment Form(s). The EDI Application form must be returned with the EDI Enrollment Form enclosed for each applicable provider.

IMPORTANT NOTE:

The address shown on the EDI Enrollment Form must match the address that was submitted to our Provider Enrollment Department when enrolling for a provider number. If the address on the completed EDI Enrollment Form does not match, your entire EDI Enrollment Packet will be returned.

The National Provider Identifier (NPI) must be printed in the space provided on the EDI Enrollment Form. If this information is missing, the EDI Enrollment Form will not be processed.

Medicare Electronic Data Interchange Enrollment Agreement

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

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contactor 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) 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 or 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 or FI or other contractor if designated by 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) agrees to:

1. Transmit to the provider an acknowledgment of claim receipt;
2. Affix the FI/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, MAC, or FI, or from any subsidiary of the carrier, MAC, FI, 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 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 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, MAC, FI, or other contractor if designated by CMS sells directly, or indirectly, or by arrangement;
6. Notify the provider within 2 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, MAC, 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: _____

Address: _____

City/State/Zip: _____

Phone: _____

Authorized Signature: _____

By (Print Name): _____

Title: _____

Date: _____ Medicare Provider Number _____

National Provider Identifier (NPI): _____

Complete ALL fields above and mail entire agreement (three pages) with **original** signature and **with** a copy of the **EDI Application form** to:

Palmetto GBA
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PO Box 100145
Columbia SC 29202-3145