



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

Provider Sign-up Form Information

Maine, Massachusetts, New Hampshire, & Vermont
Medicares

On the form marked “EDI Profile Form”, fill in the provider information.

On the form marked “ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM”, fill in and sign Section C.

If you want Electronic Remittance Advice then fill in and sign the form marked “Electronic Remittance Advice (ERA) Enrollment. You will receive your ERA from Signature Claims. NOTE: This often will END your paper EOBs.

Complete and mail this form to:
NHIC Corp.- New England
PO Box 9104
Hingham, MA 02044-9104
Attn: EDI Department

ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT PACKET

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INSTRUCTIONS FOR COMPLETING THE EDI ENROLLMENT PACKET

- ✓ *If you are applying to EDI for the first time;*
 - you must complete both the **EDI Profile Form** (page 4) and the **EDI Enrollment Form Signature Page, Section “C”** (center portion, page 6), complete all fields as directed,
 - to avoid a delay in the processing of your application you must comply with the signature/title requirements under **PROVIDER & TITLE**, on page 2,
 - mail the completed forms to your regional EDI office – **first time enrollment forms must be mailed**, they may not be faxed.
- ⇒ NOTE: NHIC, CORP MUST RECEIVE A SEPARATE ENROLLMENT FORM FOR EACH ENTITY.
- ✓ *If you already have a submitter ID and wish to *add or delete a submitter id;*
 - fax a change letter on the healthcare provider’s professional letterhead (call for fax#),
 - include the NPI & all PIN/PTAN numbers (formerly known as Provider ID, PIN #, or legacy number) to be linked/de-linked with this change letter,
 - tell us the new submitter ID# you wish to be linked with, or if you want your own new submitter number add contact names and software/operating system information to the letter,
 - tell us the submitter ID(s) you need to *be de-linked from, you must tell us what to do with every ID# on your file, *e.g., delete ID 12345, keep ID 67890*, do not keep more than 1 submitter ID.
 - the change letter must be signed by the appropriate individual, you must always comply with the signature/title requirements on page 2.
- ⇒ **You should only be linked with one submitter ID# at a time;*
 - in some circumstances a link to a second submitter ID may be necessary,
 - check with your local EDI office before you apply for an additional submitter ID; **California providers call 530-896-7024 or 213-593-6950; New England providers call 781-749-7745.**
- ⇒ *If you already have a submitter ID#, and are joining a billing agency/clearinghouse,*
 - you may use the Provider/ Submitter Agreement for Electronic Remittance Advice (ERA), instead of a letter, to add or change a submitter ID.
- ⇒ *Electronic Remittance sent to billing agency/clearinghouse: If you choose to allow a billing agent/clearinghouse to receive electronic remittance on your behalf;*
 - complete the Provider/Submitter Agreement,
 - it must be signed by both the provider and the billing agency/clearinghouse representative or ERA will not be added,
 - the billing provider portion of the form must be signed by the appropriate individual, always comply with the signature/title requirements on page 2.

⇒ *Paper Remittance*; If you wish to receive your Explanation of Medicare Benefits or Standard Paper Remittance (EOMB/SPR) by mail do not complete any ERA applications.

Read and follow all instructions to avoid a delay in the processing of your application.

⇒ *Follow Up*: If you have not received written communication from EDI approximately 10-12 working days after you have forwarded your request (*do not count Saturday and Sunday*), you may wish to call EDI and check the status of your application or correspondence. In California you may call 530-896-7024 or 213-593-6950; in New England you may call 781-749-7745.

COMPLETING THE EDI ENROLLMENT SIGNATURE PAGE, SECTION “C”

PROVIDER

The printed name of the person who will sign the document – the person requesting a new submitter ID/provider asking to be linked to an existing ID number. **NOTE: Only an individual whose title is addressed below may sign EDI application forms or submitter request correspondence.**

TITLE

The group/incorporated billing provider’s title. If the entity (group/provider) uses a DBA, the title **MUST** be President, Owner, CEO, or Owner/Partner for partnerships. If the entity does not have an individual who holds one of the titles listed above, the enrollment form may be signed by an individual who is currently on file in the PECOS system as the Authorized / Delegated Official. The title MD DO, OD, etc., will be accepted for an individual provider who uses only his/her given name.

ADDRESS

Physical address of the billing provider.

SIGNATURE

Only an ORIGINAL signature of the billing provider will be accepted. Billing agencies/clearinghouses/vendors may not sign on behalf of a provider.

TITLE

As above.

DATE

Date the application is signed.

SUBMITTER NAME/BILLING AGENT

Name of the billing provider requesting a submitter ID. If the request is being made by a billing agency/clearinghouse / vendor, enter the business name here.

SOFTWARE VENDOR

Name of the software vendor.

VENDOR PHONE

Software vendor telephone number.

SUBMITTER ID

If you are requesting a NEW submitter ID leave this section BLANK or enter “*applying for.*” If you wish to ADD a provider to an existing submitter ID please enter that submitter ID here.

PIN/PTAN*

Medicare PIN/PTAN number of the billing provider (**formerly known as Provider ID, PIN #, or legacy number*).

NPI

NPI number of the billing provider. **NOTE: On and after 10/01/2007, applications without the NPI will not be processed.**

MORE INFORMATION/LINKS

In this EDI Enrollment Packet; <http://www.medicarenhic.com/edi/download/enrollpacket.pdf>

- the EDI Profile Form (required for new applicants), and
 - EDI Enrollment Application and Signature Page (required for new applicants),
 - the EDI Provider/Submitter Agreement for ERA, complete the this form if someone else will receive electronic remittance on your behalf,
 - the Electronic Remittance Advice (ERA) Enrollment form, complete this form if you will be submitting claims directly to Medicare and wish to receive electronic remittance.
- ✓ If you already have a submitter ID#, and are joining a billing agency/clearinghouse, you may use the Provider/ Submitter Agreement for Electronic Remittance Advice (ERA), instead of a letter, to add or change a submitter ID.
- ⇒ **NOTE:** When you authorize a billing agency/clearinghouse to receive electronic remittance on your behalf, the Provider/Submitter Agreement **must** be signed by the billing provider **and** a billing agency/clearinghouse representative. The billing provider portion of the form must be signed by the appropriate individual, you must always comply with the signature/title requirements on page 2).

RE: BILLING AGENCY

- ✓ If you are adding or updating a billing agency, who will submit Medicare claims on your behalf, you must complete sections 1, 8 and 15 (8 is the billing agency section) of the CMS 855I (individual) application or CMS 855B (group/incorporated provider) application, and forward the completed form to the Provider Enrollment Department. To check on the progress of a Provider Enrollment application contact Customer Service at; 877-527-6613.
- ⇒ Once your Medicare file has been updated and the Billing Agency added to your file, attach the change confirmation letter from the Provider Enrollment Department to your EDI Request/Enrollment Form and submit it to EDI.
- ✓ **NOTE:** If you do not have Electronic Funds Transfer (EFT) in place when you add/change any Medicare file information, including billing agency information, you must send an EFT application with original signature and documentation along with your CMS 855I or CMS 855B application. Mail all required documentation to your regional Provider Enrollment Department:

NHIC Corp. - Provider Enrollment
P.O. Box 2812
Chico, CA 95927-2812

NHIC Corp. - Provider Enrollment
P.O. Box 3434
Hingham, MA 02044-3434

User friendly forms: You can now type on the PDF image of certain Centers for Medicare & Medicaid Services (CMS) forms and then print them to mail to NHIC Corp. (with original signature and any required documentation), you can also save the completed form to your computer using the “save as” command.

California providers may follow this link to user friendly CMS 855I, 855B and 855R forms

http://www.medicarenhic.com/cal_prov/enroll_forms.shtml,

Follow this link to find forms on the CMS website

http://www.cms.hhs.gov/MedicareProviderSupEnroll/03_EnrollmentApplications.asp#TopOfPage

Follow this link to the CMS 588, Electronic Funds Transfer (EFT) application and instructions

<http://www.cms.hhs.gov/cmsforms/downloads/CMS588.pdf>

Document Name: EDI Profile Form		NHIC, Corp	
Release Date: 09/11/2007		Doc. Number: FRM-EDI-0004	
		Version: 21.0	

EDI PROFILE FORM

Please complete this form and **MAIL** it with # 1, if you wish to receive *electronic remittance also send # 2 or #3:

- 1) **EDI Enrollment Form Signature Page** (original signature & appropriate title required)
- 2) Electronic Remittance Advice (ERA) Enrollment Form (ERA to you when submitting your claims directly to NHIC, Corp.)
- 3) or, Provider/Submitter Agreement (ERA to the billing agency/clearing house submitting Medicare claims on your behalf)

Mail all applicable forms to the NHIC, Corp. office that processes your Medicare Part B claims:

NHIC, Corp. - California
 Attn: EDI Department
 PO Box 2807
 Chico, CA 95927

NHIC, Corp.- New England
 Attn: EDI Department
 PO Box 9104
 Hingham, MA 02044-9104

PROVIDER OFFICE PRACTICE INFORMATION (Physical location where you PERFORM services)									
PIN/PTAN #:				NPI #:					
NAME:						DATE:			
ADDRESS:				EMAIL:					
CITY:				STATE:		ZIP:			
CONTACT (FULL NAME):				PHONE:					
CONTACT (FULL NAME):				FAX #:					
SUBMITTER INFORMATION (Who will submit claims)									
PLEASE CHECK THE APPROPRIATE BOX			PROVIDER: <input type="checkbox"/>		BILLING AGENT: <input type="checkbox"/>		CLEARING HOUSE: <input checked="" type="checkbox"/>		
NAME: SIGNATURE CLAIMS					SID# (Submitter ID#): 6046				
ADDRESS: PO BOX 7011				EMAIL ADDRESS: bi11@signatureclaims.net					
CITY: NORTHRIDGE				STATE: CA		ZIP: 91327-7011			
CONTACT (FULL NAME): BILL GREENLAND					PHONE: 818 368 5501				
CONTACT (FULL NAME):					FAX #: 641 453 5342				
SOFTWARE INFORMATION									
COMPANY: SIGNATURE CLAIMS									
CONTACT (FULL NAME): BILL GREENLAND					PHONE: 818 368 5501				
NAME OF SOFTWARE: SIGNATURE CLAIMS					OPERATING SYSTEM: WINDOWS				
ELECTRONIC REMITTANCE ADVICE									
*An Electronic Remittance Advice (ERA) file allows you to automatically post to the accounts receivable module of a practice management software. If your practice management software allows for this capability, and you would like to take advantage of this feature, choose the ERA file format check box below. NOTE: If a billing agency or clearinghouse will receive remittance on your behalf, the "Provider/Submitter Agreement" MUST also be submitted and it must be signed by the provider AND the billing agency/clearinghouse representative, or no ERA will be added to the ID#.									
COMPRESSED (ZIPPED) <input type="checkbox"/>				UNCOMPRESSED (UNZIPPED) <input type="checkbox"/>					
Take advantage of the FREE Medicare Remit Easy Print (MREP) software now available for viewing and printing the HIPAA compliant ERA! Download the MREP software available at http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp .									
BENEFICIARY ELIGIBILITY ENROLLMENT									
<input type="checkbox"/> I am requesting access to use the Beneficiary Eligibility System. I understand that I am responsible for the Medicare beneficiary data I receive. If this data is mishandled in any way, I will be held responsible in accordance with Medicare requirements.									
OFFICE USE ONLY									
NEW SID		OLD SID		ADD TO EXISTING SID		SET UP IN TEST		SET UP IN PROD	

MEDICARE – NHIC, CORP.
ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or CMS contractors.

A. The Provider Agrees:

1. That it will be responsible for all Medicare claims submitted to CMS 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 contractors, 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 signature, 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 contractor 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 of the provider on each claim electronically transmitted to the contractor;
10. That the CMS-assigned unique identifier number 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 contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (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 CMS contractor within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services will:

1. Transmit to the provider an acknowledgement of claim receipt;
2. Affix the intermediary/carrier 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 contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor 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 contractors 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 contractor 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 CMS or the contractor. 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 _____

Title _____

Address _____

City/State/Zip _____

Signature _____

Title _____

Date _____

Submitter Name/Billing Agent SIGNATURE CLAIMS

Software Vendor _____

Submitter ID 6046

Vendor Phone Number _____

PIN/PTAN Number _____

MEDICARE PART B

Electronic Data Interchange-Provider/Submitter Agreement

SECTION 1 – BILLING AGREEMENT

To be completed by **Medicare Part B Provider** if an entity is submitting claims on behalf of the provider.

Date: _____	NPI #: _____	*PIN/PTAN #: _____
Provider Name: _____		
Physical Practice Address: (<i>Where services physically performed</i>)		
Street Address: _____		
City/State/Zip: _____		
Contact Name: _____		
Phone Number: _____		
I, _____,	+	Title: _____
(PRINT NAME)		(SIGNATURE)+
Authorize; SIGNATURE CLAIMS _____		Submitter ID: 6046 _____
(SUBMITTER NAME)		
to submit claims directly to NHIC, Corp. - Medicare B electronically, and request the above provider number be **removed from Submitter ID(s): _____.		
<p>+ Authorization signature must be from the President, CEO or Owner only. **A PIN/PTAN # (*provider number) may only be linked to one submitter number. Therefore, this form will not be processed if your provider number is linked to more than one submitter number and you do not indicate what submitter number(s) to remove.</p>		

SECTION 2 – REMITTANCE AGREEMENT

To be signed by **Billing Service or Clearinghouse** only if you request to receive an Electronic Remittance File on behalf of a Medicare Part B Provider.

A billing service or clearinghouse may accept remittance files on behalf of a provider(s), but the billing service or clearinghouse is PROHIBITED from viewing, storing, modifying or reporting the data for its own use.	
_____	Title: _____
(PRINT NAME)	(SIGNATURE)
The signature on this form signifies your agreement with this requirement. This document must be signed by a representative from the Billing Service or Clearinghouse.	
All Medicare beneficiary specific information is confidential and subject to the requirements of 1106(a) of the Social Security Act.	

This form is only accepted if a current – original – EDI Agreement is on file with the NHIC Corp office that processes your Medicare Part B claims.

NHIC, Corp. - California
 PO Box 2807
 Chico, CA 95927
 Attn: EDI Department
 FAX 530-879-2668

NHIC, Corp. - New England
 PO Box 9104
 Hingham, MA 02044
 Attn: EDI Department
 FAX 781-741-3523

Join Our Electronic Mailing List for Medicare Part B

You will find the NHIC electronic updates the best way to keep informed of all Medicare changes and recently published editions of the *Medicare B Resource*.

The completed form may be mailed to: NHIC, Corp., Website Coordinator, P.O. Box 54905, Los Angeles, CA 90054-0905 or returned with your EDI enrollment forms.

Email Address*			
Provider Name *		State*	
Contact Phone Number*		Zip Code*	
County*			

*All Required Fields

NHIC does not disclose, give, sell, or transfer any personal information to third parties. See the complete [Privacy Policy](http://www.medicarenhic.com/w3c/policy.html) for more details. (<http://www.medicarenhic.com/w3c/policy.html>)

MAILING LISTS: SELECT ALL AREAS OF INTEREST	SELECT THE APPROPRIATE PROVIDER TYPE:
<p>General Mailings</p> <p><input type="checkbox"/> General NHIC Website Updates (weekly website updates)</p> <p><input type="checkbox"/> Electronic Data Interchange (EDI) Updates</p> <p><input type="checkbox"/> Seminar, Webinar, ACT (Ask the Contractor Teleconference) Notices</p> <p><input type="checkbox"/> Beneficiary Updates</p> <p><input type="checkbox"/> Medicare Easy Remit Print (MREP) Software</p> <p>Local Updates</p> <p><input type="checkbox"/> California Updates</p> <p><input type="checkbox"/> California Local Coverage Determinations (LCDs)</p> <p><input type="checkbox"/> New England Updates</p> <p><input type="checkbox"/> New England Local Coverage Determinations (LCDs)</p>	<p><input type="checkbox"/> Ambulance Service</p> <p><input type="checkbox"/> Ambulatory Surgical Center (ASC)</p> <p><input type="checkbox"/> Clinical Laboratory</p> <p><input type="checkbox"/> End Stage Renal Disease (ESRD)</p> <p><input type="checkbox"/> Hospital</p> <p><input type="checkbox"/> Physician</p> <p><input type="checkbox"/> Practice Administration</p> <p><input type="checkbox"/> Rural Health</p> <p><input type="checkbox"/> Specialty or Other _____</p>
	<p>CHECK ONE IF APPLICABLE:</p> <p><input type="checkbox"/> Billing Staff</p> <p><input type="checkbox"/> Billing Service</p> <p><input type="checkbox"/> Clearinghouse</p>