Agreement to send electronic Ohio Medicare claims

This agreement must be completed and approved by Ohio Medicare prior to sending electronic Ohio Medicare claims through Secure EDI.

1. General instructions:
   a. Use blue ink to fill the documents
   b. Complete one agreement for the group.

2. Please complete the following:
   a. Electronic Data Interchange (EDI) Enrollment Form
      • Complete the demographic information. Include the provider’s name.
      • The original signature of the Provider or Authorized Representative must be included.
      • See the included instructions for valid signers.
      • The Medicare Billing Provider Number must be included.
   
   b. EDI Change Request Form
      • Complete only if you have previously submitted claims direct or through another Clearinghouse.

3. After completing the agreement, mail the original agreement to:
   Secure EDI
   Attn: Enrollment Dept.
   200 South Tryon Street, Suite 1700
   Charlotte, NC 28202

Remember to keep a copy for your records and continue sending the claims as usually until notified of the approval of this agreement.

Please call Secure EDI at 877-466-9656 with any questions regarding this EDI Agreement.
Electronic Data Interchange (EDI) Enrollment Form

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

A. The Provider Agrees:

1. That it will be responsible for all Medicare claims submitted to CMS by 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 carrier, DMERC’s, FI’s, 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:
   a. Beneficiary’s name,
   b. Beneficiary’s health insurance claim number,
   c. Date(s) of service,
   d. Diagnosis/nature of illness, and
   e. Procedure/service performed.
5. That the Secretary of Health and Human Services or his/her designee and/or the carrier, DMERC’s, FI’s, or another contractor if so 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, 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 contractors 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 Section 1106(a) of the Social Security Act (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 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare Services will:

1. Transmit to the provider an acknowledgement 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’s 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, FI or other contractor if designated by CMS or from any subsidiary of the contractor or from any company for which the carrier, DMERC, FI or other contractor if designated by CMS 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 carrier, DMERC, FI or other contractor 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, 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 carrier, DMERC, 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.

**See Attached Instructions:**

A. Provider Name __________________________________________________________________________
B. Provider Address, City, State, ZIP __________________________________________________________________________

C. Signature & Title of Authorized Representative _________________________________________________
   Print Name of Authorized Representative _________________________________________________

D. Type of Format: ANSI 4010A1
E. Name of Software Vendor __________________________________________________________________________
F. Medicare Provider Number __________________________________________________________________________
G. National Provider Identifier (NPI) ____________________________________________________________________

H. Would you like to receive remittances electronically?  
   Yes ☐ No ☐

I. Would you like to receive files in a compressed format?  
   Yes ☐ No ☐
   If yes, indicate what type of compression.  
   Unix ☐ ZIP ☐

J. Contact Name and Phone Number ________________________________________________________________
   E-Mail ______________________________________________________________________________________

K. If there is a billing service/clearinghouse submitting claims on the providers’ behalf; please indicate the name and submittter ID (1 alpha and 5 numeric characters) OR address of the billing service/clearinghouse.

   Submitter Name:  **Electronic Network Systems, Inc.**
   Submitter ID or Address:  **N09209**

Please mail or fax the ENTIRE Enrollment Form with ORIGINAL signature to:

Palmetto GBA OH/WV, Medicare EDI Operations
PO Box 182934
Columbus, OH 43218-2934

Phone: 1-866-308-5438
Fax: 1-614-473-6802
E-mail: OHWVMEDB.EMAIL@PalmettoGBA.com
with “EDI” in the subject line.
Important Information for EDI Enrollment Form

Take Control of your Accounts Receivable and Become Compliant Now!
Sign up today to receive your remittances electronically and be ahead of the game. Download and print your remits more quickly. CMS is focused on increasing the number of providers who receive their remittances electronically and decreasing the printing and mailing costs associated with hardcopy remittances. Complete your forms today!

Medicare Remit Easy Print (MREP) software is available to enable you to view and print your Electronic Remittance Advice. For more information, contact EDI Technical Support at 1-866-308-5438 or email OHWVMEDB.EMAIL@PalmettoGBA.com with “EDI” in the subject line.

Enrollment forms are needed for each group provider number, or solo provider number if no group number exists, that wants to bill electronically. It is not necessary to send an enrollment form in for each doctor who is linked to the group number.

Before filling out page 2 of the EDI Enrollment Form please read the complete agreement.

Incomplete forms or those signed incorrectly will be mailed back to the address listed on the enrollment form. 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 not permitted to share their personal EDI access number (submitter identification number) or their password to:
- Any billing agent, clearinghouse/network service vendor;
- To anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility or to determine the status of a claim;
- Any non-staff individual or entity

Clearinghouse and other third party representatives must obtain their own unique EDI access number and password from those Medicare contractors to whom they will send or from whom they will receive EDI transactions.

The EDI access number and password act as an electronic signature, therefore the provider would be liable if any entity performed an illegal action while using that EDI access number and password. Likewise, a provider’s EDI access number and password is not transferable, meaning that it may not be given to a new owner of the provider’s operation. A new owner must obtain their own EDI access number and password.

Providers are obligated to notify Medicare by fax or hard copy 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 or
- 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.
Instructions for Completing the EDI Enrollment Form

A) Indicate Provider Name as it appears on your payment from Medicare. If you are a group practice, only one form is needed with the group information.

B) Indicate address of either physical location or remit (pay to) address. This must match the information in our system.

C) An original signature of the authorized representative is required. Note: Signature stamps are not acceptable.

Signature Requirements for “Authorized Representative”

<table>
<thead>
<tr>
<th>Type of Entity</th>
<th>Signature Requirements</th>
</tr>
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<tbody>
<tr>
<td>Individual Provider</td>
<td>Original signature of individual provider</td>
</tr>
<tr>
<td>Group Provider</td>
<td>Original signature from one of the providers of the group or an ‘acceptable signature’ listed below</td>
</tr>
<tr>
<td>Other Entities</td>
<td>Original signature from an officer of the corporation or an ‘acceptable signature’ listed below</td>
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Acceptable Signatures

- Original Signature of Provider
- Owner
- Partner
- President
- Vice President
- CEO, CFO, COO
- Chairman
- Medical Director
- Secretary of Treasure of Corporation
- Captain (for ambulance and fire specialty use only)
- Executive Director
- Authorized Office Manager

D) As of October 16, 2003, ANSI 4010A1 is the only acceptable type and version.

E) Indicate the software vendor.

F) Indicate National Provider Identifier (NPI).

G) Indicate Provider Identification Number (PIN).

If you are a group practice, please provide group numbers only. **NOTE:** If you have any questions as to your Provider name, address or PIN, please contact our Provider Enrollment area at 1-866-308-5439.

H) Indicate if you would like to establish the receipt of electronic remittance. As of October 16, 2003, ANSI 4010A1 is the only acceptable type and version.

I) Indicate if you would like to establish the receipt of files in a compressed format. If you wish to receive compressed files, indicate the format type.

J) Indicate the contact name, phone number, and email of the submitter.

K) If there is a billing service/clearinghouse submitting claims on the provider’s behalf, please indicate the name and submitter ID (1 Alpha and 5 Numeric characters) of the billing service/clearinghouse.
### EDI Change Request Form

**A. Provider Name:**

**B. Provider Number**

**National Provider Identifier:**

**C. Provider Address**

*(Where services are rendered)*

**D. Current Submitter Code (If Known):**

**E. Please complete all that apply:**

1. **Address**

2. **Remittance**
   - Yes: ☐
   - No: ☐
   
   *(NOTE: There can only be one receiver of remittance.)*

   a) **MREP**
   - Yes: ☐
   - No: ☐

3. **Compression**
   - Yes: ☐
   - No: ☐
   
   a) If yes, please indicate what type of compression
   
   ZIP: ☐
   UNIX: ☐

4. **Contact Name & Phone Number**

5. **Software Vendor**

   a. Will this replace/deactivate all current billing arrangements? Yes: ☐ No: ☐

   b. Current Arrangement End Date

6. **Billing Company/Clearinghouse Submitter Code or Name and Address**

   **Electronic Network Systems, Inc.**
   1755 Telstar Dr. Ste. 400
   **Colorado Springs, CO. 80920**

   a. Will this replace/deactivate all current billing arrangements? Yes: ☐ No: ☐

   b. Current Arrangement End Date

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**Please Note:** *If there is a change with the Billing Company/Clearinghouse or there is a request for electronic remittance, please provide a valid signature from the attachment (page 3).*

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**F. Authorized Provider Signature**

(See attachment)

**Title**

Print Name of Authorized Provider Signature

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**Palmetto GBA**

Government Programs Electronic Data Interchange (EDI) Operations, QA-610

Post Office Box 182934 ● Columbus, Ohio ● 43218-2934

*A CMS Contracted Intermediary and Carrier*
Instructions for Completing the EDI Change Request Form

Please Note: The information provided only pertains to changes for the Medicare EDI department. This information will not be forwarded to our Provider Enrollment area.

A) Indicate Provider Name as it appears on your payment from Medicare. If you are a group practice, only one form is needed with the group information.

B) Indicate National Provider Identifier and Provider Identification Number (PIN). If you are a group practice, individual PIN not required.
   NOTE: If you have any questions as to your Provider name, address or PIN, please contact our Provider Enrollment area at 1-866-308-5439.

C) Indicate address of either physical location or remit (pay to) address. This must match the information in our system.

D) Indicate submitter code (1 alpha and 5 numeric characters used when logging into the Bulletin Board to submit claims electronically).

E) This information should be given for updates and/or changes:
   1. Only indicate a change of address if you have previously notified the Medicare Provider Enrollment area.
   2. Indicate if you would like to establish or discontinue the receipt of electronic remittance. If yes, indicate the submitter code that should be receiving the remittance. NOTE: There can only be one receiver of the remittance file.
      a. Indicate if you will be using Medicare Remit Easy Print (MREP) software.
   3. Indicate if you would like to establish or discontinue receiving files in a compressed format.
      a. If you wish to receive compressed files indicate the format type.
   4. Indicate if this information has changed.
   5. Indicate the new software vendor.
      a. Indicate if this changes existing billing arrangement.
      NOTE: If this section is not completed all other arrangements will be deactivated.
   6. Indicate the New Billing Company or Clearinghouse submiter code (or name and address) that will be submitting claims to Medicare on your behalf.
      a. Indicate if this changes existing billing arrangement.
      NOTE: If this section is not completed all other arrangements will be deactivated.

F) If changes are indicated in sections E2 and E6, an authorized signature is required. Please see the attached list of valid authorized signatures (page 3).

PLEASE FAX COMPLETED FORM TO THE OHIO/WEST VIRGINIA EDI DEPARTMENT AT 614-473-6802.

If you have questions, please contact the Ohio/West Virginia EDI Technical Support office at 1-866-308-5438 or OHWVMEDB.EMAIL@PalmettoGBA.com with “EDI” in the subject line.
## Signature Requirements

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### Acceptable Signatures

- Original Signature of Provider
- Owner
- Partner
- President
- Vice President
- CEO, CFO, COO

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<td>医疗主任</td>
</tr>
<tr>
<td>Secretary of Treasure of Corporation</td>
<td>企业财务总监</td>
</tr>
<tr>
<td>Captain (for ambulance and fire specialty use only)</td>
<td>救护车和消防专业负责人仅限使用</td>
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<tr>
<td>Executive Director</td>
<td>行政总监</td>
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<td>Authorized Office Manager</td>
<td>授权办公室经理</td>
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Palmetto GBA

Government Programs Electronic Data Interchange (EDI) Operations, QA-610
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A CMS Contracted Intermediary and Carrier

- 3 -