North Carolina Medicare Part B
Palmetto GBA
837 and 835

EDI Enrollment Instructions:

- Please save this document to your computer. Open the file in the Adobe Reader program and type directly onto the form.
- Complete the forms using the credentialed information as reported on the CMS 855 Medicare Enrollment Application for the group/billing provider.
- Once completed, save, print the documents and obtain appropriate signature(s).
- Palmetto sends a confirmation notice to the email address entered on the EDI Application form.
- EDI enrollment processing timeframe is approximately 20-30 business days.

837 Claim Transactions and 835 Electronic Remittance Advice:

Medicare Electronic Data Interchange Enrollment Agreement
Not required if you are currently submitting claims electronically.

J11 EDI Application
Complete as appropriate.

J11 Provider Authorization Form
Complete as appropriate.

Submit Completed Documents:

1. Fax all (5) pages of completed documents to Palmetto
   803-699-2429
2. Fax all (5) pages of completed documents to ClaimRemedi
   707-573-1066

Medicare Electronic Data Interchange Enrollment Agreement

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS' A/B MACs or CEDI:

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 A/B MACs, DME MACs or CEDI 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 A/B MAC, DME MAC, CEDI 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 ID) of the provider on each claim electronically transmitted to the A/B MAC, CEDI or other contractor if designated by CMS;

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

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 A/B MAC, DME MAC, CEDI 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 A/B MAC, DME MAC or CEDI (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 A/B MAC, CEDI, 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 A/B MAC, DME MAC, CEDI 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 A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the A/B MAC, CEDI or from any subsidiary of the A/B MAC, CEDI, other contractor if designated by CMS, or from any company for which the A/B MAC, CEDI has an interest. The A/B MAC, CEDI, 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 A/B MACs, CEDI, 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 sold directly, indirectly, or by arrangement by the A/B MAC, CEDI, or other contractor if designated by CMS;
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 information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

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 A/B MAC, DME MAC, CEDI, 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 certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare Program (e/g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with Palmetto GBA on my behalf.

Provider's Name: ______________________________

Address: ______________________________

____

City/State/ZIP: ______________________________

Authorized Signature: ______________________________

By (Print Name): ______________________________

Title: ______________________________

Date: ______________ Medicare Provider Number ______________________

National Provider Identifier (NPI): ______________________________

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

Mailing address: **Fax number:**

Palmetto GBA
Part A/Part B/HHH EDI Operations, AG-420
PO Box 100145
Columbia SC 29202-3145

EDI Part A: 803-699-2429
EDI Part B: 803-699-2430

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

PALMETTO GBA
A CELERIAN GROUP COMPANY

Part A/Part B/HHH EDI Application

Line of Business Information: ☐ SC Part A ☐ NC Part A ☐ HHH ☐ SC Part B ☐ NC Part B ☐ VA Part B ☐ WV Part B

Action Requested: ☐ Add Provider(s) ☐ Change / Update Submitter Information ☐ Delete ☐ Apply for New Submitter ID ☐ Apply for New Receiver ID (NC Part A and VA Part B Only)

Submitter ID (if available): ____________ **Date:** ____________

Receiver ID: ____________

Submitter Name: ____________

Owner Name: ____________

Type of Submitter: ☐ Software Vendor ☐ Billing Service ☐ Provider ☐ Clearinghouse

EDI Contact Person: ____________

Phone: ____________ **Fax:** ____________

Address: ____________

____

City: ____________ **State:** ______ **ZIP:** ______

Submitter Email Address: ____________

Note: Email will be the primary method of communication.

Report Response Format:	☐ File	☐ Report
Data Compression:	☐ Uncompressed ☐ PKZIP	☐ UNIX-Compress
Name of Software Vendor:		**Vendor Security ID:**
Name of Network Service Vendor:		

Providers for Whom Submitter Will Be Transmitting

Provider Name: ____________ **Tax ID:** ____________

Provider Email Address: ____________

Provider Number: ____________ **NPI:** ____________

Enrollment Form Attached? ☐ Yes ☐ No **Provider Authorization Form Attached?** ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

Submit completed forms via mail to

Palmetto GBA
Part A/Part B/HHH EDI Operations, AG-420
PO Box 100145
Columbia SC 29202-3145

or fax to

EDI Part A: 803-699-2429
EDI Part B: 803-699-2430

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

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

Part A/Part B/HHH Provider Authorization Form

This form must be completed and signed by the Provider ONLY.

Line of Business Information: ☐ SC Part A ☐ NC Part A ☐ HHH ☐ SC Part B ☐ NC Part B ☐ VA Part B ☐ WV Part B

Action Requested: ☐ Electronic Claims Submissions ☐ Electronic Remittance ☐ Electronic Response Reports ☐ Online Inquiry Services (DDE – Part A only)

Provider for whom Submitter will be granted access

Provider Name: ______________________

Tax ID: ______________________

Provider Email Address: ______________________

Provider Number: ______________________ NPI: ______________________

Name: ______________________

Title: ______________________

Address: ______________________

____

City: ______________________ State: __________ ZIP: __________

Phone: ______________________

Submitter Name: ______________________

I hereby authorize the above submitter to receive the items notated above on my behalf. I understand that these items contain payment information concerning my processed Medicare claims. I am authorized to endorse this access on behalf of my company, and I acknowledge that is my responsibility to notify Palmetto EDI in writing if I wish to revoke this authorization.

Signature: ______________________ Date: __________

Please complete, sign and submit this form via mail or fax, with the EDI Application Form to:

Mailing address:
Palmetto GBA
Part A/Part B/HHH EDI Operations, AG-420
PO Box 100145
Columbia SC 29202-3145

Fax number:
EDI Part A: 803-699-2429
EDI Part B: 803-699-2430

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