



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.
7/25/2011 (IE, NE)

<http://www.pinnaclemedicare.com/provider/parta/edi/forms.aspx>

Medicare Part B ARKANSAS (Pinnacle Business Solutions, Inc.) Enrollment Instructions – Professional Claims & ERA

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm your EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure they are valid and accurate. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Keep a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the completed request in case you should need to follow up or resubmit.

**FAX COMPLETED FORMS TO-
EDI SERVICES, 501-378-2265**

837-CLAIMS Initial Provider Enrollment (New) or Re-Enrollment (Change of Service)

If the provider has NOT submitted claims electronically to this payer or if the provider HAS SUBMITTED electronic claims to this payer VIA ANOTHER CLEARINGHOUSE, and they now want to submit via Practice Insight, the provider must complete this form:

1. Medicare EDI Agreement (2 pages)

Page 2 – Enter Billing Provider Information. For Billing Provider's Submitter #, Enter NEW or Change of Service Enter BS AR Unique Submitter #. (For example E0123)
Signature is required by Provider or authorized Clinic or Hospital Administrator.

IMPORTANT: If the Billing Provider is currently submitting claims to BCBSAR, the Billing Provider must complete EDI Enrollment for BCBSAR and submit with MCRAR simultaneously.

835- ERAs Electronic Remittance Request (New) or (Change of Service)

For NEW enrollees-- All new EDI Submitters will be set up with Electronic Remittance Advices (ERA) automatically. If a provider is using a clearinghouse for claims, ERAS, by default, will be returned to the clearinghouse's mailbox.

For CURRENT ENROLLEES-- To authorize a Change of Service for ERAs, the following form must be completed.

1. Medicare Electronic Remittance Advice Request Form(ERA/835) (1 page)

Enter the Billing Provider's BCBS Arkansas assigned submitter ID #. Enter Billing Provider Information. Provider Signature Required.

ALLOW 2-4 WEEKS FOR PROCESSING

If it has been over 30 days since request was submitted and you have not yet received confirmation of enrollment, contact your reseller or software support vendor for assistance or call EDI Services at 1-866-582-3247.

PBSI EDI AGREEMENT

Below is the EDI Agreement, which is a required component of the entire enrollment packet for a provider submitting claims electronically, as stipulated by the Centers for Medicare and Medicaid Services.

A. The Provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS's carriers, MACs 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, 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	Diagnosis/nature of illness
Beneficiary's health insurance claim number	Procedure/service Performed
Date(s) of service	
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 (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, 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, 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 and Medicaid Services (CMS) agrees to:

1. Transmit to the Provider an acknowledgement of claim receipt.
2. Affix the carrier, MAC, FI 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, 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, or 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 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, MAC, FI or other contractor is 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 is designated by CMS sells directly, indirectly, or by arrangement.
6. Notify the Provider within two 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 carrier, MAC, 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.

Provider/Facility Name _____
Provider's Submitter # (If currently set up with EDI and making changes)

Provider's Signature (must be signed by the Provider, Clinic Administrator or Hospital Administrator) _____
Title

Printed Name of the Above Signer _____
Date **Check only one state:**
Louisiana Arkansas

Group/ Pay-to NPI # _____
Group PTAN/ Pay-to Provider # **If Arkansas, indicate line of business:**
Medicare Part A Medicare Part B

Provider's TAX ID # _____
Contact Person(s)

Phone # _____
Fax # _____
Email

All new EDI Submitters effective 03/01/09 will be set up with Electronic Remittance Advices (ERA) automatically. If a provider is using a clearinghouse for claims, PBSI, by default will return the ERA to that clearinghouse's mailbox. For more information please go to <http://www.arkmedicare.com/provider/viewarticle.aspx?articleid=7748> or <http://www.lamedicare.com/provider/viewarticle.aspx?articleid=7748>

Requesting batch 276/277 Claim Status Request and Response. Indicate the Submitter # sending 276/277 transactions: _____
(Before requesting, please verify that your software vendor and/or practice management software can generate and produce this transaction)

837 CLAIMS TRANSMISSION INFORMATION: (ONLY CHECK ONE BOX)

By checking this box, you are authorizing a Third Party/Clearinghouse/Billing Agency to send on your behalf.

*****Please supply the complete name and Submitter Number of the Clearinghouse/Billing Agency*****

Name: _____ **Submitter Number:** _____

I will be sending directly from my facility using dial up Gateway **or dial up FTP** **(requires proprietary commands See our User Guide for details)**

If you are a new direct submitter you will need to complete your vendor information below or provide the Vendor Code

Software Vendor Name _____
Vendor Code (contact your software vendor for their Vendor Code)

Address _____
City, State, Zip

Contact (printed Name) _____
Contact Email

Contact Phone # (include extension) _____
Contact Fax #

Please fax, mail, or email this completed agreement to the address or fax number below. To check on enrollment status you can email us at edi_enrollment@arkbluecross.com. Please allow 7 business days before asking for enrollment status.

RETURN ADDRESS:

EDI Services -4BC/S

PO Box 2181 Little Rock, AR 72203-2181

FedEx or UPS: 601 S. Gaines St. Little Rock, AR 72201

Service Line (501) 378-2419 Toll Free (866) 582-3247 Fax (501) 378-2265

Email: edi_enrollment@arkbluecross.com

Medicare Electronic Remittance Advice Request Form (ERA/835)

Once a provider has been receiving electronic remittance advices (ERA) transactions for Medicare Part A 30 days or Medicare Part B 45 days or more, standard paper remittance advices (SPRs) will no longer be issued.

Submitter Number of Provider/Group: _____

Submitter Number *picking up the remittance advice*: _____

Effective Date: _____

Provider Name: (Hospital, Clinic, or P.A. Group): _____

Group PTAN/Pay-to Provider Number: _____

Group/Pay-to NPI Number : _____

Address 1: _____

Address 2: _____

City/State/Zip: _____

Contact Person's Name: _____

Phone Number:

Fax Number:

Email address:

Indicate Professional (PartB) or Institutional (PartA) For ERA (ANSI 835/ERA) Transaction:

Medicare Part B Professional Medicare Part A Institutional (AR & RI only)

Indicate if you plan to use Medicare Remit Easy Print (MREP/EZPrint): Yes No

Only one submitter ID per provider number may be established for ERA. This means the submitter ID on this request will be the only recipient of ERA for the provider number(s) listed. All others will be discontinued.

Provider's Authorized signature

Title

Date

Authorized signature of the provider is one who is authorized to sign legal documents on behalf of the provider. Signatures from the billing service or clearinghouse are not accepted.

RETURN ADDRESS:

Medicare EDI Services 4-BC/S

P.O. Box 2181

Little Rock, AR 72203-2181

FedEX or UPS: 601 S. Gaines St. Little Rock, AR. 72201

Fax: (501) 378-2265

Service Line: (866) 582-3247 edi@arkbluecross.com