



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.  
12/27/2011 (IE, NF)  
(FE,IE Added Note to check only 4010 and NOT 5010)  
<http://www.ngscedi.com/forms/formsindex.htm>

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## DMERC- Regions A, B, C and D - Jurisdiction 1 CEDI (National Governments Services, 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.** In particular, make sure provider IDs And NPI #'s are valid and entered correctly. Incorrect information will cause the request to be rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Keep copy of the completed request in case you should need to follow up.

GO TO NGS CEDI web link at <http://www.ngscedi.com/forms/formsindex.htm>  
Scroll down to see the links to open the online forms described below.

**FORMS MUST BE COMPLETED ONLINE, PRINTED, SIGNED, DATED  
AND FAXED DIRECT TO CEDI NGS at 315-442-4299**

### 837- Claims and 835-ERAs (New)

If this is the FIRST TIME this billing provider has enrolled for 837-Claims and/or 835-ERAs with this payer, these forms must be completed.

#### 1. CMS EDI Enrollment Form

ENTER Supplier Name, (Billing Provider's group name, or individual provider's name ONLY if individual provider is billing solo.

ENTER Billing Provider's Contact Name, Address, City, State, Zip, Email Address, etc.

ENTER Billing Provider's PTAN (Supplier #) and NPI Number

SELECT "Existing Submitter" in the Submitter Status drop-down menu.

ENTER Submitter ID: **B08003310**

ENTER Submitter Name: **Practice Insight, LLC**

SELECT "Clearinghouse" in the Submitter Type drop-down menu.

Once form is completed, click "Submit", then **Print, Sign, Date** and **Fax** direct to CEDI.

#### 2. CEDI Supplier Authorization Form (SEE instructions on next page.)

### 837- Claims and 835-ERAs (Change of Service)

If the provider is CURRENTLY SUBMITTING CLAIMS and/or RECEIVING ERAs (remits) either directly or through another service company and the provider wishes to CHANGE SERVICE to authorize Practice Insight as their Clearinghouse, this form must be completed online.

#### 1. CEDI Supplier Authorization Form (SEE instructions on next page.)

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INSTRUCTIONS FOR COMPLETING the “CEDI Supplier Authorization Form” -

- ✓ “Health Care Claim (837 v5010A1)”
- ✓ “Health Care Claim Payment/Advice (835 v5010Aa)”  
(Check “835” ONLY, if you want electronic Remits.  
Otherwise, DO NOT Check “835 v5010A1”).

ENTER this information to include Practice Insight data, as follows:

Entity Name: **Practice Insight, LLC**  
Operating as a: **Clearinghouse**  
Submitter ID: **B08003310**  
Street Address: **1 Greenway Plaza, Suite 350**  
City: **Houston** State: **Texas** Zip: **77046**  
Contact Name: **Enrollment**  
Contact Phone Number: **713-333-6000** Ext: **2**  
Contact Email Address: [enrollment@practiceinsight.net](mailto:enrollment@practiceinsight.net)  
Verify Email Address: [enrollment@practiceinsight.net](mailto:enrollment@practiceinsight.net)

SEE Section, “DME Supplier Information”

Complete this information to include the Provider’s/Supplier’s information.

Once form is completed, click “**Submit**”, then **Print, Sign, Date** and **Fax** direct to CEDI.

\*\*\*\*\***ATTENTION**\*\*\*\*\*

**The Following Pages are EXAMPLES ONLY!**  
**Provider must visit the website and complete these forms**  
**ONLINE according to the above instructions.**

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**ALLOW 2-4 WEEKS FOR PROCESSING**

*If you do not receive confirmation within 30 days, contact your EDI Solutions Reseller or Support person for assistance or call CEDI Help Desk at 1-866-311-9184*



[Help](#)

## CEDI Enrollment Agreement Form

\* - Required

Medicare Supplier Name	<input type="text"/>	Submitter Status	Existing Submitter
Contact Name	<input type="text"/>	Submitter ID	B08003310
Address	<input type="text"/>	Submitter Name	Practice Insight, LLC
City/State/Zip	<input type="text"/> -- <input type="text"/>	Submitter Type	Clearinghouse
Email	<input type="text"/>	PTAN(s)	<input type="text"/>
Verify Email	<input type="text"/>	NPI (s)	<input type="text"/>
Phone	<input type="text"/> * Ext <input type="text"/>		

**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

I have read and accept the terms of the above agreement.

Authorized Signature Name

**IMPORTANT:** Once you click on the "Submit" button, this form must be printed, signed, dated, and then faxed to CEDI using the fax number located on the form. Forms that are not printed, signed, dated, and faxed to CEDI will not be processed. **Per CMS regulations, it is required to submit both pages 1 and 2 of the EDI Enrollment Agreement. Failure to submit both pages may delay processing.**

**ALL pages of ALL forms must be SIGNED, DATED, and FAXED to 315-442-4299 within 10 business days or the request will be rejected. Please be sure to fax multiple forms for the same request TOGETHER and include a cover letter. Faxes not received within 10 days of submitting the form(s) on line will be rejected and new forms will be required to be submitted.**

CMS strictly prohibits any trading partner from outsourcing system functions overseas, unless explicitly authorized, in writing, by the CMS CIO. System functions include the transmission of electronic claims, receipt of electronic remittance advice or the access to any system for beneficiary and/or eligibility information. Any request for access by an overseas party will be immediately denied by National Government Services pending authorization from CMS.



[Help](#)

## CEDI Supplier Authorization Form

U.S. Department of Health and Human Services

### Select Transactions Authorized for this Submitter

- Health Care Claim (837 v5010A1)
- Health Care Claim Status Request & Response (276/277 v5010)
- Health Care Claim Payment/Advice (835 v5010A1)
- NCPDP Claims D.O

### Submitter and/or Receiver Information

Entity Name  \*

Operating as a  \*

Submitter ID  \*

Street  \*

City/State/Zip  \*  \*  \*

Contact Name  \*

Phone Number  \* Ext  \*

E-mail  \*

Verify E-mail  \*

### DME Supplier Information

Supplier Name  \*

Street  \*

City/State/Zip  \* --  \*  \*

Contact Name  \*  \*

Phone Number  \* Ext  \*

E-mail  \*

Verify E-mail  \*

### List your NPI and your NSC/PTAN Number(s) Below (Required):

PTAN(s) <input type="text"/> *	NPI <input type="text"/> *
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**IMPORTANT:** Once you click on the "Submit" button, this form must be printed, signed, dated, and then faxed to CEDI using the fax number located on the form. Forms that are not printed, signed, dated, and faxed to CEDI will not be processed. Requests received 30 days past the Signature date will be returned.

ALL pages of ALL forms must be SIGNED, DATED, and FAXED to 315-442-4299 within 10 business days or the request will be rejected. Please be sure to fax multiple forms for the same request TOGETHER and include a cover letter. Faxes not received within 10 days of submitting the form(s) on line will be rejected and new forms will be required to be submitted.

Enter the name and title of the person authorized to sign on behalf of the supplier below.

DME Supplier Signature  \*

DME Supplier Title  \*