



Medicare Part B - FLORIDA

First Coast Service Options, 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 to make sure provider IDs are valid. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Make a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the enrollment pages in a file that can be easily referred to, should you need to follow up or resubmit the request.

FAX COMPLETED FORMS TO-
Medicare Florida EDI
904-361-0470

837- CLAIMS Initial Provider Enrollment (New)

If the provider has NOT submitted claims electronically to this payer, the provider must complete these forms:

1. Electronic Data Interchange – Fax Coversheet Required. (1 page)
2. Medicare EDI Enrollment Form (3 pages)
Complete Section C. and lower portion of Section D.

837- CLAIMS Provider Re-Enrollment (Change of Service)

If the provider is currently submitting electronic claims, either directly or through another service company, and would like to submit through Practice Insight, the provider must complete the form:

1. Electronic Data Interchange – Fax Coversheet Required. (1 page)
2. EMC Change of Information Form (2 pages)
Complete Section B.

835- ERAs (New) or (Change of Service)

To authorize Practice Insight, to retrieve Medicare FL ERAs, complete the ONLINE EDR (Electronic Data Request) (Complete this form for each billing provider group and/or for individual provider(s) billing solo).

1. Electronic Data Interchange – Fax Coversheet Required. (1 page)
2. **Access the EDR Form ONLINE, at http://medicare.fcso.com/EDI_forms/138245.pdf**
Scroll down first 2 pages of instructions. See EDR form on page 3.

See LAST PAGE of this document for EXAMPLE OF COMPLETED ONLINE EDR FORM.

- REFER to the data on the EXAMPLE FORM to complete Sections A, B, and C and SKIP Section D.
- ENTER Provider specific information in Section E.
- AFTER completing the form online, Click [PRINT FORM] and SIGN (see where Provider must SIGN).
- FAX the 2-page EDR form to Medicare EDI Fax # at 1-904-361-0470.

ALLOW 2-4 WEEKS FOR PROCESSING

If you do not receive confirmation within 30 days, contact your reseller for assistance or call Florida Medicare EDI department at 888-670-0940 option-4 (Enrollment-EDI).



WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

Electronic Data Interchange -- Fax coversheet

(REQUIRED)

- This fax contains sensitive information including PHI (personal health information) or PII (personally identifiable information).

Date:

Number of pages including cover:

From:

Email:

Phone:

Fax:

To: Medicare EDI
Phone: (888) 670-0940
Fax: (904) 361-0470 Enrollment
(904) 361-0430 DDE/ASCA

Please indicate what type of information you are faxing. If the proper box is not checked it may delay processing.

EDI enrollment request

(EDI enrollment form, electronic data request, EMC change of information form, New installation/change of vendor form, PC ACE application, or network service agreement)

DDE (direct data entry)

(DDE application with or without NSA form, user ID request, recertification)

ASCA documentation

Other (please specify)

PRIVILEGED AND CONFIDENTIAL

The information contained in this document may be confidential and is intended solely for the use of the individual or entity to whom it is addressed. This document may also contain material that is privileged or protected from disclosure under applicable law. If you are not the intended recipient or the individual responsible for delivery to the intended recipient, please (1) be advised that any use, dissemination, forwarding, or copying of this document IS STRICTLY PROHIBITED; and (2) notify sender immediately by telephone and confirm destruction of the document. Thank you.

EDI Enrollment Form

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

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 FIs, Carriers, RHHIs, 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 the FI, Carrier, RHHI, 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 identifier) of the provider on each claim electronically transmitted to the FI, Carrier, RHHI, A/B Mac, CEDI, 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 FI, Carrier, RHHI, 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 FI, Carrier, RHHI, 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 FI, Carrier, RHHI, 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 FI, Carrier, RHHI, 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 FI, Carrier, RHHI, A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the FI, Carrier, RHHI, A/B MAC, CEDI or from any subsidiary of the FI, Carrier, RHHI, A/B MAC, CEDI, other contractor if designated by CMS, or from any company for which the FI, Carrier, RHHI, A/B MAC, CEDI has an interest. The FI, Carrier, RHHI, 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 FIs, Carriers, RHHIs, 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 FI, Carrier, RHHI, 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 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 FI, Carrier, RHHI, 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.



**MEDICARE
Electronic Data Interchange**

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 First Coast Service Options (FCSO) on my behalf.

Provider's Name

Title

Address

City/State/ZIP

By _____ (signature) _____ (printed name)

Date

Email Address of Provider's Office Contact Person to Receive Approval Letter

D. Please provide the following Medicare information. All fields are required unless otherwise indicated.

Submitter Number (Conditionally required if not applying for a new submitter number)

Billing Service/Clearinghouse Name (Optional)

Contact Person (Optional)

Phone Number (Optional)

Check below all that apply:

Medicare Part A provider's NPI

If you are a member of a group, indicate the group NPI

Medicare Part B provider's NPI

If you are a member of a group, indicate the group NPI

Tax Identification or Social Security Number _____

Mailing Address:

Medicare EDI
PO Box 44071-3C
Jacksonville FL 32231-4071

Phone & Fax Numbers:

Phone: 1-888-670-0940 Option 4
Fax: 1-904-361-0470

Physical Address:

Medicare EDI
532 Riverside Ave 3C
Jacksonville FL 32202-4918



**MEDICARE
Electronic Data Interchange**

EMC CHANGE OF INFORMATION FORM

To avoid any delays in processing, please make sure you complete the information in each section that applies to the specific EMC type of change requested.

Section A: Type of Change - Select one per request and complete each Section specified.

_____ Add a Provider to an existing submitter number. Complete Sections B: 1-8, and C: 1.

(Provider is required to have a valid EDI Enrollment Form on file).

_____ Delete a provider from an existing submitter number. Complete Sections B: 1-8 and C: 1.

_____ Delete a submitter number. **This will delete the submitter number entirely.**
Please complete Section C: 1-7.

_____ Change of submitter address. Complete Section C: 1-5.

_____ Change of submitter contact person. Complete Section C: 1 and 5.

_____ Change Submitter Email Address: Complete Section C: 1, 2 and 6.

Section B: Provider Information - All Fields Are Required (Refer to the selection in Section A)

1. **Provider name:** _____
2. **Provider address:** _____
3. **City/State/ZIP:** _____
4. **NPI (National Provider Identifier):** _____
5. **Tax ID/SS Number:** _____
6. **Name of person requesting this change:** _____
7. **Signature of provider or authorized party for the provider:** _____
8. **Email address of provider or authorized party for the provider to receive approval letter:**

9. **Effective Date:** _____

Section C: Submitter Information - All Fields Are Required Unless Indicated Otherwise (Refer to the selection in Section A)

1. **Submitter number:** _____
2. **Submitter name of company** (Conditional): _____
3. **Submitter address** (Conditional): _____
4. **City/State/ZIP** (Conditional): _____
5. **Contact person** (Conditional): _____
6. **Email address:** _____
7. **Telephone No** (Conditional): _____ **Fax No** (Conditional): _____
8. **Effective Date** (Conditional): _____

Fax or mail completed form to:	Medicare EDI	Medicare EDI
Fax: 904-361-0470	Attn: Enrollment Team – 3C	Attn: Enrollment Team – 3C
Phone: 1-888-670-0940, option 4	P.O. Box 44071	532 Riverside Avenue
	Jacksonville, FL 32231-4071	or Jacksonville, FL 32202-4918



Electronic data request (EDR) form

SECTION A: REQUEST TYPE. Please check one. This section is required.

- Add electronic remittance advice ASC X12N 835 version 5010
- Delete electronic remittance advice ASC X12N 835 version 5010
- Add electronic claims status request and response ASC X12N 276/277 version 5010 (Not supported by PC-ACE Pro32® software)
- Delete electronic claims status request and response ASC X12N 276/277 version 5010

Note: The provider is required to have a signed EDI enrollment form on file. Failure to have an EDI enrollment form on file will result in the EDR form being returned.

The Centers for Medicare & Medicaid Services (CMS) strictly prohibits any trading partner from outsourcing system functions overseas, unless explicitly authorized, in writing, by the CMS Chief Information Officer (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 pending authorization from CMS.**

SECTION B: SUBMITTER INFORMATION. All fields in this section are required unless otherwise indicated.

Submitter number (conditional- required when adding or deleting a transaction to an existing submitter):	<input type="text" value="P6472"/>		
Submitter name:	<input type="text" value="Practice Insight, LLC"/>		
Mailing address:	<input type="text" value="1 Greenway Plaza, Suite 350"/>		
City/State/ZIP:	<input type="text" value="Houston, TX 77046"/>		
Contact name:	<input type="text" value="Donna Anderson/Jessica Wettstein"/>	Position:	<input type="text" value="EDI Enrollment Specialist"/>
Telephone:	<input type="text" value="(713) 333-6000"/>	Extension:	<input type="text" value="Opt 2"/>
Fax (optional):	<input type="text" value="(712) 333-0138"/>	email address (required):	<input type="text" value="enrollment@practiceinsight.net"/>

SECTION C: VENDOR INFORMATION. The software support vendor can assist with this section. All fields in this section are required unless otherwise indicated.

Vendor name:	<input type="text" value="Practice Insight, LLC"/>	Contact (optional):	<input type="text" value="Enrollment Department"/>
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SECTION D (Optional): DEFAULT DELIMITERS. Contact your software support vendor for assistance with this section. If you are using the PC-ACE Pro32® software, leave blank. If your software supports the default delimiters, leave blank.

The default delimiters returned on electronic remittance advice are:

- * (2A hex value) for element delimiter;
- > (3E hex value) for sub-element delimiter; and
- Line Feed (0A hex value) for segment delimiter.

If alternate values are required, indicate below.

Element: Sub-element: Segment

SECTION E: PROVIDER INFORMATION. All fields in this section are required unless otherwise indicated. If the provider is a member of a group, indicate the group's NPI. If the provider has multiple NPIs, please indicate all the NPIs to receive electronic remittance. Only the NPIs indicated below will be attached to the submitter number on this form. All provider identifier numbers linked to the NPIs given will be setup at time of processing unless otherwise indicated.

By signing below, I authorize the indicated electronic data request addition or deletion.

Signature/title:

Effective date: email address:

Medicare Part B provider:
(Name of provider)

Provider's Tax Identification Number (TIN) or Social Security Number (SSN):

NPI: Provider identifier number: (optional):

NPI: Provider identifier number: (optional):

NPI: Provider identifier number: (optional):

Medicare Part A provider:
(Name of provider)

Provider's Tax Identification Number (TIN) or Social Security Number (SSN):

NPI: Provider identifier number: (optional):

NPI: Provider identifier number: (optional):

NPI: Provider identifier number: (optional):

[Print Form](#)

