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**Medicare Part B- Hawaii**  
**(Includes Samoa, Guam, and Northern Mariana Islands)**  
**Palmetto GBA**  
**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 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 pages that are submitted, in case you need to follow up on this request.

**MAIL COMPLETED FROMS TO-**  
Palmetto GBA  
Jurisdiction 1, AG-420  
PO Box 100145  
Columbia SC 29202-3145

**837-Claims and 835-ERAs (New) or (Change of Service)**

To authorize Practice Insight as submitter of electronic claims and receiver of electronic reports these forms must be completed for each Medicare billing provider group or individual provider, if billing solo.

1. Palmetto GBA EDI Application (2 pages; only use 2<sup>nd</sup> page to enroll additional billing providers)  
SEE **"Date:"** Enter Date the application is completed.  
SEE **"Providers for Whom Submitter Will be Transmitting"**- ENTER the Billing Provider's information.  
**Optional for ERAs:** For each Billing Provider- Put ✓ for **"Receive Electronic Remittances"**
2. Medicare Electronic Data Interchange Enrollment Agreement (3 pages)  
SEE **Page 3, Section C.** Enter the Billing Provider's information.
3. Palmetto GBA Provider Authorization Form (1 page)  
SEE **"Provider for whom Submitter will be granted access"**- ENTER the Billing Provider's information.  
**Optional for ERAs** See **"Action Requested"**-- Put ✓ for **"Electronic Remittance"**

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**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 Palmetto GBA edi dept at 1-866-749-4301.*



**Jurisdiction 1  
Electronic Data Interchange Application**

Line of Business Information:  Part A  Part B

CA  NV  HI (Note: Includes Samoa, Guam and Northern Mariana Islands)

Action Requested:  Add Provider(s)  Change / Update Submitter Information  
 Delete  Apply for New Submitter ID

Submitter ID (if available): \_\_\_\_\_ Date: \_\_\_\_\_

Submitter Name: \_\_\_\_\_

Owner Name: \_\_\_\_\_

Type of Submitter:  Software Vendor  Billing Service  Provider  Clearinghouse

EDI Contact Person: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Submitter E-mail Address: \_\_\_\_\_

Note: E-mail will be the primary method of communication.

Claim Submission Mode of Communication:	<input type="checkbox"/> GPNET Asynchronous <input checked="" type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Dial-up FTP <input type="checkbox"/> Leased FTP
Report / Electronic Remittance Retrieval Mode of Communication:	<input type="checkbox"/> GPNET Asynchronous <input checked="" type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Dial-up FTP <input type="checkbox"/> Leased FTP
Report Response Format:	<input checked="" type="checkbox"/> File	<input type="checkbox"/> Report
Data Compression:	<input checked="" type="checkbox"/> Uncompressed (GPNET Default) <input type="checkbox"/> PKZIP	<input type="checkbox"/> UNIX-Compress
Name of Software Vendor: Self		Vendor Security ID: _____

**Providers for Whom Submitter Will Be Transmitting:**

Provider Name: _____			
Provider E-mail Address: _____			
Provider Number: _____ NPI: _____			
Enrollment Form Attached? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No		
<input checked="" type="checkbox"/> Submit Claims	<input checked="" type="checkbox"/> Receive Reports	<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Submit completed form to: **Palmetto GBA**  
 J1 EDI Operations, AG-420  
 PO Box 100145  
 Columbia, SC 29202-3145

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



**Jurisdiction 1  
Electronic Data Interchange Application**

**Multiple Providers List**

Date: \_\_\_\_\_

**PROVIDERS FOR WHOM SUBMITTER WILL BE TRANSMITTING:**

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Submit Claims	<input checked="" type="checkbox"/> Receive Reports <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Submit Claims	<input checked="" type="checkbox"/> Receive Reports <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Submit Claims	<input checked="" type="checkbox"/> Receive Reports <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input checked="" type="checkbox"/> Submit Claims	<input checked="" type="checkbox"/> Receive Reports <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Online Inquiry Services

Please mail this form to: **Palmetto GBA**  
 J1 EDI Operations, AG-420  
 PO Box 100145  
 Columbia, SC 29202-3145

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

## **Medicare Electronic Data Interchange Enrollment Agreement**

### **A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers, MACs, or FIs:**

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 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;
  - 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 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 number (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 or 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 or 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 & Medicaid Services (CMS) agrees to:**

1. Transmit to the provider an acknowledgment of claim receipt;
2. Affix the FI/carrier/MAC 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, 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, 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 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 carriers, MACs, FIs, 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 the carrier, MAC, FI, or other contractor if designated by CMS sells directly, or indirectly, or by arrangement;
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 carrier, MAC, FI, 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 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's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

By (Print Name): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_ Medicare Provider Number \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

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

Palmetto GBA  
J1 EDI Operations, AG-420  
PO Box 100145  
Columbia, SC 29202-3145



Jurisdiction 1  
Provider Authorization Form

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

Line of Business Information:  Part A  Part B

Action Requested:  Electronic Claims Submissions  Electronic Remittance  
 Electronic Response Reports  Online Inquiry Services (PPTN or DDE)

Provider for whom Submitter will be granted access:

Provider Name: \_\_\_\_\_

Provider E-mail 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 and return this form, with the EDI Application Form, to:

Palmetto GBA  
J1 EDI Operations, AG-420  
PO Box 100145  
Columbia, SC 29202-3145