Practice Insight

Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.
4/3/2012 (IE)
http://www.wpsic.com/edi/med_macj5.shtml

Medicare Part B - Jurisdiction 5
IOWA, KANSAS, MISSOURI-EASTERN, MISSOURI-WESTERN, NEBRASKA
(Wisconsin Physicians Service)
Enrollment Instructions - Professional Claims and 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-
WPS Medicare EDI, 608-223-3824

837 - CLAIMS Provider Enrollment (New)

If the provider has NOT submitted claims electronically to this payer before and wishes to authorize Practice Insight to submit claims, the billing provider must complete this form:

1. EDI Enrollment Form (3 Pages)

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

If the provider wishes to request a CHANGE of Service to authorize Practice Insight to submit claims, the billing provider must complete this form:

1. WPS EDI Change of Submitter Form (1 Page)

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

If the provider has never registered for ERA files -Or if the provider currently receives 835 ERA files and wishes to authorize Practice Insight to retrieve their 835 ERA files, the provider must complete this form:

1. WPS Authorization Form for Electronic Remittance Advice Processing (ERA) (2 Pages)

ALLOW 2-4 WEEKS FOR PROCESSING

If you do not receive confirmation of edi enrollment within 30 days, contact your reseller/support vendor for assistance or call WPS at 1-866-503-9670.

EDI ENROLLMENT FORM

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 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, MAC s, 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, 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 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 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' 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 Name ____

Provider Address ____

City/State/Zip__________________________________ __________ _________________

By ________________________________ ________________________________
Signature Printed name

Title____ Date________________________

Check all lines of business that apply:
Part A J5 [ ] Part B J5 [ ] Part B Legacy [ ] Part A Legacy [ ]

<u>Type of Submission</u> (check all that apply)
Electronic Media Claims (EMC) ________
Direct Data Entry (DDE) ________

NPI Number__________________________________ PTAN Number____________________

WPS Submitter Number: _________________ ***(Required for batch billing only)***

Provider Contact Name ___________________________ Phone # _______________________

Provider Email ___________________________________ Fax # _________________________

[ ] By checking this box, you are authorizing a Third Party/Clearinghouse/Software vendor to send your Electronic Media Claims (EMC).

***** Please supply the complete name of the Third Party/Clearinghouse/Software vendor *****

Name: _________________________Address:_____________________________________

City: __________________ State: _________ Zip: __________ Fax Number: ___________________

Contact:___________________________Contact Email address: _________________________
(Printed Name)

Contact Phone Number: _________________________ WPS Submitter Number:________________
(Please include extension #)

Please mail or fax this completed agreement to:

<u>Medicare Part A & B J5 MAC</u>
(IA, KS, MO, NE)
WPS Medicare EDI
1717 West Broadway
Madison, WI. 53713
Fax: (608) 223-3824
Phone: (866) 503-9670

<u>Medicare Part A Legacy</u>
(Multiple States)
WPS Medicare EDI
PO Box 1602
Omaha, NE 68101
Fax: (402) 995-0606
Phone: (866) 734-6656

<u>Medicare Part B</u>
(IL, MI, MN, WI)
WPS Medicare EDI
912 N Pentecost Drive
Marion, IL 62959
Fax: (618) 998-5170
Phone: (877) 567-7261

WPS HEALTH INSURANCE

EDI CHANGE OF SUBMITTER FORM

Check all lines of business that apply:
Part A J5 [ ] Part B J5 [ ] Part B Legacy [ ] Part A Legacy [ ]

NPI Number______________________________ PTAN Number___________________

Change (aka New) WPS Submitter Number: _______________ Effective Date:________________

Note: All information in shaded area is required.

Signature
I am authorized to sign this document on behalf of the indicated party. I am aware that any changes to the submitter ID may affect the receipt of electronic remittance advice (ERA). Any changes regarding ERA will require a new ERA Authorization Form (http://www.wpsic.com/edi/pdf/edi_ern_medb.pdf).

Provider Name ____

Provider Address ____

City/State/Zip______________________________ _______ ________________

By _____________________________ _____________________________
Signature Printed name

Title______________________________________ Date______________________

Provider Contact Name ________________________ Phone # ________________________

Provider Email ______________________________ Fax # __________________________

Please mail or fax this completed form to:

Medicare Part A & B J5 MAC
(IA, KS, MO, NE)
WPS Medicare EDI
1717 West Broadway
Madison, WI. 53713
Fax: (608) 223-3824
Phone: (866) 503-9670

Medicare Part A Legacy
(Multiple States)
WPS Medicare EDI
PO Box 1602
Omaha, NE 68101
Fax: (402) 995-0606
Phone: (866) 734-6656

Medicare Part B
(IL, MI, MN, WI)
WPS Medicare EDI
912 N Pentecost Drive
Marion, IL 62959
Fax: (618) 998-5170
Phone: (877) 567-7261

Wisconsin Physicians Service (WPS) Authorization Form for Electronic Remittance Advice Processing (ERA)

This form is intended to establish Electronic Remittance Advice (ERA) enrollment. The implementation process cannot begin until this questionnaire is completed. **If the form is received as not legible or not completed correctly, it will be returned to the provider for correction.** If you are a direct submitter, you must be assigned a submitter ID in order to receive the ERA. If you have not registered for a submitter ID, please access the WPS Trading Partner System (WTPS) at the following website: https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do. If you are not a direct submitter, the clearinghouse/third-party company/billing service submitter number should be used. Please return this form to the EDI Department, for the applicable line of business, as listed at the bottom of this form.
******This request could take up to fourteen business days to complete. ******

Part A providers need to select if this request is for a new submitter or if they want to add providers to their current submitter.
New Submitter: [ ]   Add Providers: [ ]

<u>Check all lines of business that apply:</u>

Part A J5 [ ]   Part B J5 [ ]   Part B Legacy [ ]   Part A Legacy [ ]

<u>Please identify the company that will be retrieving the Electronic Remittance Advices ERA) in this section:</u>

Provider/Physician: [ ] Corporate Office: [ ]   Third Party Company/Clearinghouse: [ ]

Provider Name: ____

Provider Street Address: ____
(If the provider will be retrieving the ERAs, then they need to include the address that the services are rendered)

Provider City/ State/Zip: ____

Contact Person: ____
(Printed Name)

Contact Phone #:______________________ Contact Fax #:______________________
(Please incl. ext #)

Contact Email Address: ____

WPS Submitter ID: __________________
(Please use only the WPS issued submitter ID that will be retrieving the ERAs)

Provider Identification Numbers:
Multiple providers may be listed on this form if they are at the same location. To retrieve ERA for additional providers at different locations, please complete a separate authorization form for each additional provider number.

Provider Name	Provider Number	NPI Number

I, ________________________________ of _______________________________ would like to
(Provider Contact Signature) (Provider Name)

receive ERAs effective, ____________________. (**All providers MUST include an effective date for this request)**
(Date)

☐ By checking this box, you are authorizing a Third Party Company/Clearinghouse to Retrieve ERA files on your behalf.

Please supply the complete name and address of theThird Party Company/Clearinghouse.

Name: _________________________________ Address: ____

City: _____________________________ State: ________ Zip: ___________ Fax #:_________________________

Contact: ______________________________________ Contact Phone #:_____________________________
(Printed Name) (Please include extension #)

Contact Email Address: ____

Translation Software: If you are a direct submitter, you will need translation and printing software in order to view and print the Electronic Remittance Advice. MREP software, for part B providers, and PCPrint software for part A providers, is available to download from our website at the following addresses:

MREP: *http://www.wpsmedicare.com/part_b/business/mrep.shtml*

PCPrint: *http://www.wpsmedicare.com/part_a/business/pc_print.shtml*

Please mail or fax this completed agreement to:

Medicare Part B Legacy: IL, MI, WI, MN	**Medicare Part A & B J5: IA, NE, KS, MO**	**Medicare Part A Legacy: (multiple states)**
WPS Electronic Data Services	WPS	WPS
912 N. Pentecost Rd.	Attention: EDI	Attention: EDI
PO Box 5511 Marion, IL 62959	1717 W. Broadway Madison, WI 53713	P.O. Box 1602 Omaha, NE 68101
Phone # (877) 567-7261	Phone # (866) 503-9670	Phone # (866) 734-6656
Fax : (618) 998-5170	Fax : (608) 223-3824	Fax: (402) 995-0606