



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.
4/25/2012 (FE)

<https://www.novitas-solutions.com/edi/enrollment/forms-a-b.html>

Medicare Part B – PENNSLVANIA Novitas Solutions 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 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 submitting the request. Keep a copy of the paperwork that is submitted, in case you should need to follow up on your request.

FAX COMPLETED FORMS TO-
Novitas Solutions, Inc.
877-439-5479

837-CLAIMS and 835- ERAs Billing Provider Enrollment (New) or (Change of Service)

If the provider has NOT submitted electronic claims to this payer before, or if the provider wishes to request a CHANGE of SERVICE to authorize Practice Insight to submit claims and/or retrieve ERAs (electronic remits), the billing provider must complete and submit these forms:

1. CMS Electronic Data Interchange (EDI) Enrollment (3 pages + pg w/Completion Instructions)

In Section B, C, and D - Enter the billing provider's information.

In Section E - For "**Name of Software Vendor**"- Enter Practice Management software

For "**Name of Company who will be preparing electronic claims**"

Put ✓ by "**Provider**" or "**Billing Service**" and enter name of Billing Service.

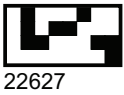
SEE Page 3 of 4 - SIGNATURE

Enter **Name** and **Title** of authorized person to sign this request.

PRINT, then obtain **Signature** and Enter the **Date** - AFTER the form is printed.

ALLOW 2-4 WEEKS FOR PROCESSING

If you do not receive confirmation within 20 days after submitting the EDI enrollment request, contact your reseller for assistance or call Novitas Solutions EDI Dept. at 1-877-235-8073 to request status of enrollment.



22627



ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT

Novitas Solutions, Inc. A CMS CONTRACTOR

All fields marked with * are required and must be completed. Detailed instructions are available on the last page of this document.

A *Click all contracts that apply: [] Part A (Institutional) [] Part B (Professional) [] J12901 [] DC (Part A) [] DCMA (Part B) [] DE [] MD [] NJ [] PA OFFICE USE ONLY

B *NAME OF GROUP, PHYSICIAN, PROVIDER, OR SUPPLIER (Must match the name on file with Medicare as reported on the CMS-855 Enrollment form)

C PRACTICE LOCATION: (as reported on CMS-855 Enrollment form) *STREET ADDRESS *CITY *STATE *ZIP CODE *CONTACT PERSON *TELEPHONE # Ext. FAX # E-MAIL ADDRESS FOR LISTSERV AND ENROLLMENT RESPONSE ENVIRONMENTALLY FRIENDLY OPTION: If additional PTANs are linked to my submitter ID in the future, I do not need the traditional paper mail response. Only mail me my initial enrollment letter.

D *NPI # *Provider Transaction Access Number (PTAN) For Affiliated PTANs, attach a signed list on company letterhead, if needed (Part A only).

E COMPLETE THE VENDOR, BILLING SERVICE, AND/OR CLEARINGHOUSE INFORMATION: [] PC-ACE Pro32 (only check if enrolling for the Medicare-issued software.) Name of software vendor: *Who will be preparing the electronic claims? [] Provider (same as above) [] Clearinghouse [] Billing Service *Who will be submitting the electronic claim files? [] Provider (same as above) [] Clearinghouse [] Billing Service [] The CMS 855 Section 8 was already sent to Provider Enrollment Services for the same company that is both preparing and submitting claims. Refer to the instructions for block E on page 4 of this form for more information on this requirement.

F *REQUEST TYPE: (Requests will be processed for the PTAN provided above in the most recent HIPAA-compliant format/version.) [] Add to existing submitter ID: [] Enroll for Claim Status (276/277) [] Assign this provider a new electronic billing submitter ID. For Part B, please choose one: [] Direct Data Entry Only (DDE) (Part A only) [] Vendor Change Only [] One submitter ID [] Separate submitter IDs per contract. [] ERA Change Only

G [] PART B ONLY: MAINTAIN EXISTING SUBMITTER ID SET-UP FOR 45 DAYS If the provider number listed in Block D is associated with any other submitter number(s), Medicare will remove the other submitter number(s) before assigning a new submitter number unless this box is checked. If checked, Medicare will maintain the existing submitter ID setup for 45 days only. After 45 days, the submitter number will be removed from the provider without additional notice. This option is for Part B customers only. *If you receive ERA it will be sent to only one submitter ID. If you are linked to two submitter IDs the ERA will be sent to the ID with the lowest numeric value as a default.

H ELECTRONIC REMITTANCE ADVICE (ERA) Upon completion of this form, ERA will be available on a daily basis, based on claim finalization, and is only available for retrieval for 45 days. After 45 days from the ERA creation date, the ERA is no longer available on the telecommunication platform. Posting problems with the ERA may be encountered if you maintain multiple submitter IDs. For Part B customers, the ERA can only be generated under one ID. If you are linked to multiple submitter/receiver IDs you must choose one as the ERA receiver. For Part A customers, the paper remittance will continue for thirty (30) days after the effective date of ERA. For Part B customers, the paper remittance will continue for forty-five (45) days after the effective date of ERA. You will no longer receive paper remittances after these time-frames. Check the box if a different ID is needed to retrieve your ERA than is sending claims. [] Request separate ERA receiver ID (Part B customers will receive all ERAs under this number) ERA Receiver ID (Part B customers only):

I [] ENROLL FOR PC-ACE PRO32 SOFTWARE TERMS: • Novitas Solutions, Inc. (Novitas) is authorized to distribute PC-ACE Pro32/PRINTLINK/ETRA (herein referred to as the "Program") to authorized users. PC-ACE Pro32 and PRINTLINK software programs are copyrights of Medlink Technologies. The Program is distributed for the purpose of creating electronic Medicare claim files only. Any use not authorized herein is strictly prohibited, including but not limited to, making copies of any part of the Program, reselling or transferring copies to any party, or creating any modified or derivative work.



SOFTWARE TERMS, continued:

- The Program is provided "as is" without warranty of any kind, either expressed or implied, including but not limited to the implied warranties of merchantability or fitness for particular purpose.
- In no event will Novitas be liable for any loss or damage, including but not limited to incidental or consequential damages, arising out of the use or inability to use the Program even if Novitas has been advised of the possibility of such damages, or for any claim by any other party.
- The authorized user will upgrade this Program within 90 days of upgrade availability. This is a CMS requirement.
- The authorized user will provide the necessary office space, all electrical and telephone connections, hardware, telecommunication software and equipment that adhere to the technical requirements located at:
<https://www.novitas-solutions.com/edi/pc-ace/pc-ace-pro-32.html>
- Internet download is the preferred method of software installation. Internet download instructions will be provided upon processing of this enrollment. There is no fee for software installation via Internet download. To receive the Program in CD-ROM format, visit <https://www.novitas-solutions.com/edi/pc-ace/index.html> for ordering instructions. A non-refundable \$100 annual service fee is required. This service fee covers four quarterly PC-ACE Pro32 releases.

AGREEMENT

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

The Provider Agrees:

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 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, 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, 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, or CEDI (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 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.

The Centers for Medicare & Medicaid Services (CMS) will:

1. Transmit to the provider an acknowledgement of claim receipt.

2. Affix the FI, Carrier, RHHI, A/B 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's 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 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, RHHI, A/B MACs, CEDI, or other contractor 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, CEDI, or other contractor if designated by CMS. Novitas reserves the right to terminate this agreement if there is no EDI activity within a six (6) month period. You agree that Novitas will be entitled to damages, court costs and reasonable attorney's fees if you breach this agreement. Either party may terminate this agreement 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.

ATTESTATION

Any provider who submits Medicare claims electronically to CMS or its contractors remains responsible for those claims as those responsibilities are outlined on the EDI Enrollment. In accepting claims submitted electronically to the Medicare Program from any billing service or through the use of a particular product which accomplishes this process, neither CMS, nor any other Medicare contractors are attesting to the appropriateness of the methods used by the billing service/clearinghouse or to the accuracy of a particular vendor's product used to facilitate such electronic submissions. The provider furnishing the item or service for whom payment is claimed under the Medicare Program retains the responsibility for any claim regardless of the format it chooses to use to submit the claim.

I understand that an authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of five percent or more (see Section 5 of the CMS-855 Enrollment form for a definition of "direct owner"), or must hold a position of similar status and authority within the provider's organization.

I understand that any individual who knowingly and willfully makes or causes to be made any false claim or false statement of false representation of a material fact in any application to the federal government for benefits or payment with respect to the Medicare program may be subject to civil and/or criminal enforcement action which may result in fines, penalties, damages and/or imprisonment.

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 Novitas Solutions on my behalf.

A dial-up modem is often required for transmitting electronic claims. Prior to signing this agreement, please carefully review the technical requirements for electronic billing in Chapter 3 of the Electronic Billing Guide.

* AUTHORIZED OFFICIAL ORIGINAL SIGNATURE <i>(add after you print out the form)</i>	* DATE <i>(add after you print out the form)</i>
* NAME OF AUTHORIZED OFFICIAL	* TITLE

COMPLETE FORM, PRINT, SIGN, DATE AND MAIL OR FAX ALL PAGES TO:

Novitas Solutions, Inc. - EDI, P.O. Box 890011, Camp Hill, PA 17089-0011
or Fax: 1 (877) 439-5479

FIELD	COMPLETION INSTRUCTIONS FOR THE EDI ENROLLMENT (8292)
A	Click all applicable boxes for the areas that you handle Medicare billing.
B	Type the name of the group, physician, provider, or supplier enrolling for EDI. The name listed must match the name on file at Medicare for the PTAN listed in Block D.
C	<ul style="list-style-type: none"> ▶ Type the practice address, including suite/building numbers/levels, of the group, physician, provider, or supplier enrolling for EDI. The address must match the address on file at Medicare for the PTAN listed in Block D. ▶ Type the contact person's name who has the knowledge and authority to answer questions regarding your enrollment. ▶ Type the telephone number (including area code) of the contact person listed and their extension. ▶ Type the FAX number (including area code) of the group, physician or supplier. ▶ Type the e-mail address of the contact person. The e-mail address will be added to our listserv mail groups and an e-mail will be sent when the form is received and processed. ▶ Click the "Environmentally Friendly Option..." if you do not want to receive any mail responses after the initial letter. If checked, only the e-mail will be sent to provide enrollment details. An e-mail address must be provided.
D	<ul style="list-style-type: none"> ▶ Type the NPI of the group, physician, provider, or supplier enrolling in EDI. The Medicare PTAN and the NPI are required and must match the number on file at Medicare. ▶ Type the PTAN of the group, physician, provider, or supplier enrolling for EDI. If you are requesting approval for multiple PTANs, a separate EDI form must be completed for each provider number/practice. If you are billing under a group PTAN, only one EDI form should be completed using the group PTAN. The number reported must match the number on file at Medicare for the group, physician, provider, or supplier name listed in Block A and be linked to the NPI.
E	Type or print the name of your vendor and the name of the company(s) preparing and sending the files. If you are using (or enrolling to use) PC-ACE Pro32, check the appropriate box for the PC-ACE Pro32, if applicable and also supply the name of the company(s) preparing and sending your files. If the same company, other than the provider's office, both prepares and submits your electronic claims, the appropriate CMS-855 form information will be required in addition to your EDI Enrollment form. The CMS-855 requires an original signature, therefore, when sending an EDI Enrollment form and a CMS-855 form, they must be mailed to the address listed below. Failure to complete the CMS-855 will result in your EDI Enrollment form being returned. Details on required information to be included in block E of the 8292 and on the CMS-855 is located at: https://www.novitas-solutions.com/edi/enrollment/forms-a-b.html The CMS-855 is located at https://www.novitas-solutions.com/enrollment/form-855.html
F	Click the appropriate box based on your enrollment needs. <ul style="list-style-type: none"> ✓ Click the "Add to existing..." box if you want to add a provider to an already existing submitter ID, and type or print the submitter number on the corresponding line. ✓ Click the "Assign this provider..." option if you are requesting a new electronic billing submitter ID. ✓ Click the "One submitter ID or Separate submitter ID..." box to show if you are requesting one submitter per contract or separate. ✓ Click the "Enroll for Claim Status..." box if you want to send and receive 276/277 transactions for status of your electronic claims. ✓ Click the "DDE only" box if you are only enrolling for DDE and no other electronic features (except 835). ✓ Click the "Vendor Change Only" box if you are only changing vendors. There are no changes needed to your existing submitter ID. ✓ Click the "ERA Change Only" box if you are only making changes to your ERA enrollment.
G	This option is for Part B customers only. If you are requesting to maintain an existing submitter, click the box provided. Unless a request is provided asking to maintain an existing submitter ID, Medicare will remove the old submitter ID before assigning a new submitter ID. Caution: Multiple submitter IDs may cause posting problems with your ERA for Part B customers. Multiple submitter IDs are not permitted for Part A customers and are strongly discouraged for Part B customers.
H	<ul style="list-style-type: none"> ▶ Electronic billers will automatically be enrolled for ERA upon the completion of the EDI enrollment process. ▶ Click the "Request separate ERA receiver ID" box if a different ID is needed to retrieve your ERA than the submitter ID sending claims. If you already have a receiver ID, type it in the space provided. If you do not have one, leave blank, and a new one will be assigned.
I	Click the "Enroll for PC-ACE Pro32" box if you want to use the Medicare issued PC-ACE Pro32 software program.
Signature	<ul style="list-style-type: none"> ▶ Type the name of the authorized signature. ▶ Type the title of the person signing the form.