

**MEDICARE A RURAL - FQHC (RH450/00450)
Medicare NGS (National Government Services)
Enrollment Instructions – Institutional 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 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-
NGS EDI Setup Department, 502-423-2356

837- CLAIMS and 835-ERAs (Initial Request) or (Change of Service)

The billing provider must complete the following steps and submit both online forms if requesting to authorize Practice Insight as the submitter/receiver for either 837-Claims or 835-ERAs, or both.

1. Go to the <http://www.ngsmedicare.com/OnlineForms/EDIEnrollmentAgreement.aspx>
SEE Part A Wisconsin and Click on “Go to Home Page”
Select Forms (See Quick Links) and select **EDI Enrollment Agreement Form** (listed under Electronic Data Interchange)

For “Provider Information” - ENTER Billing Provider’s information (See fields in left columns.)

Enter Submitter Information as follows:

Submitter Status: **Existing Submitter**

Submitter ID: **CH0000471**

Submitter Name: **Practice Insight, LLC**

Submitter Type: **Clearinghouse**

For “Contractor Code”, SELECT from list,
“**Part A WI 00450**”

For PTAN(s) Enter Billing Provider’s unique
Medicare group or billing
legacy Pin #.

For NPI(S): Enter Billing Provider’s group
or billing NPI #.

Click “Submit”, then print, sign and fax to 502-423-2356.

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2. Go to the <http://www.ngsmedicare.com/OnlineForms/EDIEnrollmentAgreement.aspx>
See Part A Wisconsin and Click on “Go to Home Page”
Select Forms (See Quick Links) and select **EDI Third Party Authorization Form** (listed under Electronic Data Interchange)

- **UNDER** “Select Transactions Authorized for this Submitter”

For CLAIMs: **Put** ✓ **ASC X12 837 Claims V4010A1**

For ERAs: **Put** ✓ **ASC X12 835 Remittance V4010A1**

(Select ERAs ONLY if you want to receive electronic remits. Otherwise, do not check this transaction.)

NOTE: Even if the provider is already enrolled “837Claims” it is still necessary to place a ✓ for ASCX12 837 Claim when requesting ASC X12 835 Remittance.

- **UNDER** “Submitter and/or Receiver Information”

Name: **Practice Insight, LLC**

Operating As: **Clearinghouse**

Submitter ID: **CH0000471**

Address: **1 Greenway Plaza, Suite 350
Houston, TX 77046**

Contact: **Enrollment Dept.**

Phone: **713.333.6000** Ext: **2**

Email: **enrollment@practiceinsight.net**

- **UNDER** “Provider Information”

Enter the **Billing Provider’s** information, including PTAN(s), NPI Number (for billing provider or group)

For Contractor Code: SELECT from list, “**Part A WI 00450**”

Click “**Submit**”, print, sign and fax to 502-423-2356.

**See the following pages for an EXAMPLE of
completed online request form pages.**

ALLOW 2-4 WEEKS FOR PROCESSING

If you do not receive confirmation of enrollment within 20 business days after faxing your request, contact National Government Services EDI at 1-877-273-4334



EDI Enrollment Agreement Form

* - Required

Provider Name	<input type="text" value="JOE SMITH"/>	Submitter Status	<input type="text" value="Existing Submitter"/>
Title	<input type="text" value="MD"/>	Submitter ID	<input type="text" value="CH0000471"/>
Address	<input type="text" value="1000 Main St"/>	Submitter Name	<input type="text" value="Practice Insight, LLC"/>
City	<input type="text" value="Madison"/> <input type="text" value="WI"/> <input type="text" value="53705"/>	Submitter Type	<input type="text" value="Clearinghouse"/>
Email	<input type="text" value="jsmith@abcphysicians.com"/>	Contractor Code	<input type="text" value="Part A WI 00450"/>
Verify Email	<input type="text" value="jsmith@abcphysicians.com"/>	PTAN(s)	<input type="text" value="44556678"/>
Phone	<input type="text" value="555-123-4455"/> Ext <input type="text" value="123"/>	NPI(s)	<input type="text" value="1234567890"/>

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

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, then faxed the EDI Enrollment Department. Requests received 30 days past the Signature date will be returned. -- Additional fax information can be found on the printed form.

ALL pages of ALL forms must be SIGNED, DATED, and FAXED to 502-423-2356 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.



[Help](#)

EDI Third-Party Provider Authorization Form

U.S. Department of Health and Human Services

Select Transactions Authorized for this Submitter

- ASC X12 837 Claim V4010A1
- ASC X12 276/277 Claim Status & Response V4010A1
- ASC X12 835 Remittance V4010A1

Submitter and/or Receiver Information

Name Practice Insight, LLC *

Operating as a Clearinghouse *

Submitter ID CH0000471 *

Street 1 Greenway Plaza, Suite 350 *

City/State/Zip Houston TX 77046 *

Contact Name Enrollment Department *

Phone Number 713-333-6000 * **Ext** 2

Email Address enrollment@practiceinsight.net *

Verify Email Address enrollment@practiceinsight.net *

Provider Information

Name Joe Smith *

Street 1000 Main St *

City/State/Zip Madison WI 53705 *

Contact Name MARY SHAW *

Phone Number 555-123-4455 * **Ext** 123

Email Address jsmith@abcphysicians.com *

Verify Email Address jsmith@abcphysicians.com *

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

PTAN(s)	NPI
44556678 *	1234567890 *

Contractor Code Part A WI 00450 *

Signature Name *

ALL pages of ALL forms must be SIGNED, DATED, and FAXED to 502-423-2356 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.

Submit