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## Medicare Part B - Texas TrailBlazer – Jurisdiction 4 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.

**For 837- MAIL COMPLETED FORMS TO-**

ATTN: Enrollment Department  
Practice Insight, LLC  
1 Greenway Plaza, Suite 350  
Houston, TX 77046

**For 835- FAX COMPLETED FORM TO-**

TrailBlazer Health Enterprises, LLC at 469-372-1045

### **837- CLAIMS Initial 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 these forms:

1. *TrailBlazer*- EDI Provider Information Form (1 page)
2. Medicare Electronic Data Interchange (EDI) Enrollment Agreement (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. *TrailBlazer*- EDI Provider Information 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. *TrailBlazer*- Medicare Part B Electronic Remittance Advice (ERA) Request Form (1 page)  
ENTER: Provider Name and Address, etc. at top of form.  
ADD: Provider #, NPI, and Signature on bottom of form.

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**ALLOW 2-4 WEEKS FOR PROCESSING**

*If you do not receive confirmation within 30 days, contact your reseller for assistance or call TrailBlazer Technology Center Support Line at 1-866-749-4302.*



## EDI Provider Information Form

<b>1. Provider Data</b>	(To be completed by provider)	Date:
Name:		
Address:		
City, State, ZIP:		
Primary Contact:		
Phone Number:		Fax Number:
E-mail Address:		
Please Check One: <input type="checkbox"/> Part A Provider <input type="checkbox"/> Part B Provider		
Please Check Applicable State: <input type="checkbox"/> CO <input type="checkbox"/> NM <input type="checkbox"/> OK <input type="checkbox"/> TX		
NPI (National Provider Identifier):		Provider Number:
Submitter ID (if available):		
<p><b>I certify that I am legally empowered to sign this form on behalf of the Legal Business Name identified on this form. I acknowledge that in signing this, I bind this company or unincorporated organization to notify the Medicare contractor in advance and in writing if changes have occurred to information reported in this form or if it is necessary to revoke any designations made in the form. I certify that the information I have supplied is accurate. As a Medicare provider/supplier, I understand that in signing this form I am responsible for payment of any fees for EDI services charged by a designated EDI submitter/receiver with whom I have elected to conduct business. I also understand that any acknowledgement, error reports, or query responses related to submitted transactions will be returned to any designated EDI submitter/receiver with whom I have authorized on this form and that Medicare contractors are not permitted to send duplicate copies of outbound transactions to my organization as well as to the designated EDI submitter/receiver.</b></p>		
Signature _____		Printed Name _____
Title _____		Date _____
Action Requested:		
<input type="checkbox"/> Provider is Submitter (Provider submits claims directly from their office)		
<input type="checkbox"/> Provider is with Billing Service/Clearinghouse (Section 3 must be completed)		
<b>2. EDI Software Vendor Data</b>	(To be completed by vendor)	
Company Name:		
Primary Contact:		Phone:
Vendor Code:		Fax:
<b>3. EDI Billing Service/Clearinghouse Data (To be completed by billing service/clearinghouse)</b>		
Company Name:		
Primary Contact:		Phone:
Submitter ID:		Fax:

## 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 two 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 two 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): \_\_\_\_\_

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Complete ALL fields above and mail entire agreement (three pages) with *original* signature to:

TrailBlazer Health Enterprises, LLC  
EDI Operations, AG-507  
P.O. Box 100249  
Columbia, SC 29202-3249

## Medicare Part B Electronic Remittance Advice (ERA) Request Form

**Note:** Please allow 10 days for processing and an additional 3–5 business days for notification via mail.

<b>Provider Name and Address:</b> *** Provider Information Required ***		<b>Receiving Name and Address:</b> Address of clearinghouse, vendor or billing agency downloading and processing ERA data. *** Not required if provider does his own download. ***	
<b>E-mail Address:</b>		<b>E-mail Address:</b>	
<b>Existing ERA Receiver Number:</b>			
<b>Contact Person (Full Name):</b>			
<b>Is this a new contact name?</b>	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Phone Number:</b>	( )	<b>Fax Number:</b>	( )
<b>Type of Remittance: MAILBOX (GPNet):</b>	<input type="checkbox"/> Zipped	<input type="checkbox"/> Unzipped	
<b>Format: ANSIX12 835 version 005010X221A1</b>			
<b>Provider Number:</b>		<b>NPI Number:</b>	
*** Group, solo or organization number only. Do not list group member numbers. ***			

If the provider downloads and processes his own ERA data, signing this form certifies he will not share his receiver number and password with any other entity. If remittance is to be provided to a clearinghouse, software vendor or billing agency, the provider's signature signifies approval for them to do the download.

**Provider Signature:** \_\_\_\_\_  
(Or representative legally empowered to sign this form on behalf of the provider name identified on this form.)

Mail or fax this form to:

TrailBlazer Health Enterprises, LLC  
P.O. Box 660156  
Dallas, TX 75266-0156  
Fax: (469) 372-1045