



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.  
8/18/2011 (IE,FE)  
[http://medicare.fcso.com/EDI\\_forms/](http://medicare.fcso.com/EDI_forms/)

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## Medicare Part B – Virgin Islands

First Coast Service Options, Inc.  
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 customer account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck to make sure provider ID #s 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 submitted paperwork, in case you need to follow up on your request.

**FAX COMPLETED FORMS TO-**  
Medicare EDI , 904-361-0470

### 837-CLAIMS Billing Provider Enrollment (New)

If the provider has NOT submitted claims electronically to this payer, the provider must complete the form:

1. Medicare EDI Enrollment Form (3 pages)  
Complete Section C. and lower portion of Section D.

### 837-CLAIMS Billing Provider Enrollment (Change of Service)

If the provider is currently submitting electronic claims, either directly or through another service company, and would like to submit through Practice Insight, the provider must complete the form:

1. EMC Change of Information Form (2 pages)  
Complete Section B.

### 835 - ERAs Electronic Remittance Request (New) or (Change of Service)

To authorize Practice Insight, to retrieve Medicare ERAs, complete the ONLINE EDR (Electronic Data Request) (Complete this form for each billing provider group and/or for individual provider(s) billing solo. **Access the EDR Form ONLINE, at [http://medicare.fcso.com/EDI\\_forms/138245.pdf](http://medicare.fcso.com/EDI_forms/138245.pdf)**  
Scroll down first 2 pages of instructions. See EDR form on page 3.

**See LAST PAGE of this document for EXAMPLE OF COMPLETED ONLINE EDR FORM.**

- REFER to the data on the EXAMPLE FORM to complete Sections A, B, and C and SKIP Section D.
- ENTER Provider specific information in Section E.
- AFTER completing the form online, Click [PRINT FORM] and SIGN (see where Provider must SIGN).
- FAX the 2-page EDR form to Medicare EDI Fax # at 1-904-361-0470.

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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 the Medicare EDI department at 888-670-0940 option-1.*

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**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, 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, 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 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.



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**C. Signature:**

I am authorized to sign this document on behalf of the indicated party and I have read and agreed to the foregoing provisions and acknowledge same by signing below.

Provider's Name

Title

Address

City/State/ZIP

By

(signature)

(printed name)

Title

Date

**D. PLEASE PROVIDE THE FOLLOWING MEDICARE INFORMATION**

Submitter Number  
(Conditionally required if  
not applying for a new  
submitter number)

All Fields Are Required Unless  
Otherwise Indicated

Contact Person  
(optional):

Billing Service/Clearinghouse Name  
(optional)

Telephone Number  
(optional):

Check below all that apply:

- Medicare Part A provider's NPI
- Medicare Part B provider's NPI (If you are a member of a group, indicate the group's NPI.)
- Tax Identification or Social Security Number

**Mailing Address:**  
Medicare EDI  
PO Box 44071 – 3C  
Jacksonville, FL 32231-4071

**Phone and Fax Numbers:**  
Phone: 1-888-670-0940, option 4  
Fax: 904-361-0470

**Physical Address:**  
Medicare EDI  
532 Riverside Ave. 3C  
Jacksonville, FL 32202-4918



**MEDICARE  
Electronic Data Interchange**

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**EMC CHANGE OF INFORMATION FORM**

To avoid any delays in processing, please make sure you complete the information in each section that applies to the specific EMC type of change requested.

**Section A: Type of Change** - Select one per request and complete each Section specified.

\_\_\_\_\_ Add a Provider to an existing submitter number. Complete Sections B: 1-8, and C: 1.

**(Provider is required to have a valid EDI Enrollment Form on file).**

\_\_\_\_\_ Delete a provider from an existing submitter number. Complete Sections B: 1-8 and C: 1.

\_\_\_\_\_ Delete a submitter number. **This will delete the submitter number entirely.**  
Please complete Section C: 1-7.

\_\_\_\_\_ Change of submitter address. Complete Section C: 1-5.

\_\_\_\_\_ Change of submitter contact person. Complete Section C: 1 and 5.

\_\_\_\_\_ Email Address Change: (Indicate Here) \_\_\_\_\_  
Complete Section C: 1 and 2.

**Section B: Provider Information** - All Fields Are Required Unless Indicated Otherwise (Refer to the selection in Section A)

1. **Provider name:** \_\_\_\_\_
2. **Provider address:** \_\_\_\_\_
3. **City/State/ZIP:** \_\_\_\_\_
4. **NPI (National Provider Identifier):** \_\_\_\_\_
5. **Tax ID/SS Number:** \_\_\_\_\_
6. **Name of person requesting this change:** \_\_\_\_\_
7. **Signature of provider or authorized party for the provider:** \_\_\_\_\_
8. **Effective Date:** \_\_\_\_\_

**Section C: Submitter Information** - All Fields Are Required Unless Indicated Otherwise (Refer to the selection in Section A)

1. **Submitter number:** \_\_\_\_\_
2. **Submitter name of company** (Conditional): \_\_\_\_\_
3. **Submitter address** (Conditional): \_\_\_\_\_
4. **City/State/ZIP** (Conditional): \_\_\_\_\_
5. **Contact person** (Conditional): \_\_\_\_\_
6. **Telephone No** (Conditional): \_\_\_\_\_ **Fax No** (Optional): \_\_\_\_\_
7. **Effective Date** (Conditional): \_\_\_\_\_

Fax or mail completed form to:	Medicare EDI	Medicare EDI
Fax: 904-361-0470	Attn: Enrollment Team – 3C	Attn: Enrollment Team – 3C
Phone: 1-888-670-0940, option 4	P.O. Box 44071	532 Riverside Avenue
	Jacksonville, FL 32231-4071	or Jacksonville, FL 32202-4918



## Electronic data request (EDR) form

### SECTION A: REQUEST TYPE. Please check one. This section is required.

- Add electronic remittance advice ASC X12N 835 version 4010A1
- Delete electronic remittance advice ASC X12N 835 version 4010A1
- Add electronic claims status request and response ASC X12N 276/277 version 4010A1 (Not supported by PC-ACE Pro32® software)
- Delete electronic claims status request and response ASC X12N 276/277 version 4010A1

**Note:** The provider is required to have a signed EDI enrollment form on file. Failure to have an EDI enrollment form on file will result in the EDR form being returned.

The Centers for Medicare & Medicaid Services (CMS) strictly prohibits any trading partner from outsourcing system functions overseas, unless explicitly authorized, in writing, by the CMS Chief Information Officer (CIO). System functions include the transmission of electronic claims, receipt of electronic remittance advice or the access to any system for beneficiary and/or eligibility information. **Any request for access by an overseas party will be immediately denied pending authorization from CMS.**

### SECTION B: SUBMITTER INFORMATION. All fields in this section are required unless otherwise indicated.

Submitter number (conditional- required when adding or deleting a transaction to an existing submitter):	<input type="text" value="P6472"/>		
Submitter name:	<input type="text" value="Practice Insight, LLC"/>		
Mailing address:	<input type="text" value="1 Greenway Plaza, Suite 350"/>		
City/State/ZIP:	<input type="text" value="Houston, TX 77046"/>		
Contact name:	<input type="text" value="Donna Anderson/Jessica Wettstein"/>	Position:	<input type="text" value="EDI Enrollment Specialist"/>
Telephone:	<input type="text" value="(713) 333-6000"/>	Extension:	<input type="text" value="Option 2"/>
Fax (optional):	<input type="text" value="(713) 333-0138"/>	email address (required):	<input type="text" value="enrollment@practiceinsight.net"/>

### SECTION C: VENDOR INFORMATION. The software support vendor can assist with this section. All fields in this section are required unless otherwise indicated.

Vendor name:	<input type="text" value="Practice Insight, LLC"/>	Contact (optional):	<input type="text" value="Enrollment Department"/>
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**SECTION D (Optional): DEFAULT DELIMITERS.** Contact your software support vendor for assistance with this section. If you are using the PC-ACE Pro32® software, leave blank. If your software supports the default delimiters, leave blank.

The default delimiters returned on electronic remittance advice are:

- \* (2A hex value) for element delimiter;
- > (3E hex value) for sub-element delimiter; and
- Line Feed (0A hex value) for segment delimiter.

If alternate values are required, indicate below.

Element:  Sub-element:  Segment

**SECTION E: PROVIDER INFORMATION.** All fields in this section are required unless otherwise indicated. If the provider is a member of a group, indicate the group's NPI. If the provider has multiple NPIs, please indicate all the NPIs to receive electronic remittance. Only the NPIs indicated below will be attached to the submitter number on this form. All provider identifier numbers linked to the NPIs given will be setup at time of processing unless otherwise indicated.

**By signing below, I authorize the indicated electronic data request addition or deletion.**

Signature/title:

Effective date:  email address:

Medicare Part B provider:   
(Name of provider)

Provider's Tax Identification Number (TIN) or Social Security Number (SSN):

NPI:  Provider identifier number: (optional):

NPI:  Provider identifier number: (optional):

NPI:  Provider identifier number: (optional):

Medicare Part A provider:   
(Name of provider)

Provider's Tax Identification Number (TIN) or Social Security Number (SSN):

NPI:  Provider identifier number: (optional):

NPI:  Provider identifier number: (optional):

NPI:  Provider identifier number: (optional):

[Print Form](#)