



Questions? Please contact your EDI solutions reseller for help with EDI enrollment forms.

10/14/11 (FE)

[http://www.palmettogba.com/Palmetto/Providers.Nsf/files/EDI_Enroll_J11_Pack.pdf/\\$File/EDI_Enroll_J11_Pack.pdf](http://www.palmettogba.com/Palmetto/Providers.Nsf/files/EDI_Enroll_J11_Pack.pdf/$File/EDI_Enroll_J11_Pack.pdf)

Medicare Part B - VIRGINIA JURISDICTION 11- Palmetto GBA 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 account setup.
- ✓ **Make sure all required information is complete and accurate** Recheck provider numbers to be sure they are valid and accurate. 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 completed request in case you should need to follow up or resubmit.

MAIL COMPLETED FORMS TO-
Palmetto GBA
J11 EDI Operations, AG-420
P O Box 100145
Columbia, SC 29202-3145

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

To authorize Practice Insight as submitter of electronic claims and receiver of electronic reports these forms must be completed for each Medicare billing provider group or individual provider, if billing solo.

1. Palmetto GBA J11 EDI Application (2 pages; use 2nd page if enrolling additional billing providers.)
SEE **"Date:"** Enter Date the application is completed.
SEE **"Providers for Whom Submitter Will be Transmitting"**- ENTER the Billing Provider's info.
Optional for ERAs: For each Billing Provider- Put ✓ for **"Receive Electronic Remittances"**
2. Medicare Electronic Data Interchange Enrollment Agreement (3 pages)
SEE **Page 3, Section C.**
Enter the Billing Provider's information to include billing provider's specific information-
Provider's PTAN # and NPI #. (If billing as group, enter group NPI # and group MCR PTAN #.
"Authorized Signature", Signer's "Printed Name", "Title" and "Date" also required.
3. Palmetto GBA J11 Provider Authorization Form (1 page)
SEE **"Action Requested"** Put ✓ for **"Electronic Remittance"** (Optional- only if requesting ERAs)
SEE **"Provider for whom Submitter will be granted access"**-
SEE bottom of page **"Signature"** and **"Date"** (Authorized person in provider's office must sign.)

ALLOW 2-4 WEEKS FOR PROCESSING

If you do not receive confirmation within 30 days, contact your Practice Insight Reseller/Support Vendor for assistance, or call Palmetto GBA EDI department at 1-866-749-4301 to get status of your edi enrollment request.



J11 EDI Application

Multiple Providers List

Date: _____

PROVIDERS FOR WHOM SUBMITTER WILL BE TRANSMITTING:

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Submit completed form to: **Palmetto GBA**
 J11 EDI Operations, AG-420
 PO Box 100145
 Columbia SC 29202-3145

Please retain a copy for your records.
 You must submit a completed EDI Application Form when submitting additional EDI forms.

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 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'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 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's Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Authorized Signature: _____

By (Print Name): _____


Title: _____

Date: _____ Medicare Provider Number _____

National Provider Identifier (NPI): _____

Complete ALL fields above and mail entire agreement (three pages) with **original** signature and **with** a copy of the **EDI Application form** to:

Palmetto GBA
J11 EDI Operations, AG-420
PO Box 100145
Columbia SC 29202-3145

 <h2 style="margin: 0; display: inline-block; margin-left: 20px;">J11 Provider Authorization Form</h2>
This form must be completed and signed by the Provider ONLY.
Line of Business Information: <input type="checkbox"/> SC Part A <input type="checkbox"/> NC Part A <input type="checkbox"/> HHH <input type="checkbox"/> SC Part B <input type="checkbox"/> NC Part B <input type="checkbox"/> VA Part B <input type="checkbox"/> WV Part B
Action Requested: <input type="checkbox"/> Electronic Claims Submissions <input type="checkbox"/> Electronic Remittance <input type="checkbox"/> Electronic Response Reports <input type="checkbox"/> Online Inquiry Services (PPTN or DDE)
Provider for whom Submitter will be granted access
Provider Name: _____
Provider E-mail Address: _____
Provider Number: _____ NPI: _____
Name: _____
Title: _____
Address: _____ _____
City: _____ State: _____ ZIP: _____
Phone: _____
Submitter Name: _____
I hereby authorize the above submitter to receive the items notated above on my behalf. I understand that these items contain payment information concerning my processed Medicare claims. I am authorized to endorse this access on behalf of my company, and I acknowledge that is my responsibility to notify Palmetto EDI in writing if I wish to revoke this authorization.
Signature: _____ Date: _____

Please complete and return this form, with the EDI Application Form, to:

Palmetto GBA
 J11 EDI Operations, AG-420
 PO Box 100145
 Columbia SC 29202-3145