

Noridian EDI Support Services EDI Enrollment Form Completion Instructions

These instructions will assist you in completing the Electronic Data Interchange (EDI) Enrollment Form. All sections must be filled out. **Print legibly and complete every section as accurately as possible.** Although this document is to aid you in the completion of this form, if you have questions, please contact EDI Support Services (EDISS) at 800-967-7902.

SIGNATURE SECTION

On page two of the EDI Enrollment Form, there is a signature section. The signature section needs to be filled out completely and signed in ink by the provider. If the provider's signature is not available, a signature of someone from the facility holding a management position or higher will be accepted. If the provider/facility has been assigned a group provider/clinic number, EDISS requires the signature of the individual who has the authority to enter into contracts on behalf of the group. **The form with an original ink signature must be mailed to EDISS to avoid any interruptions in your ability to exchange data with EDISS.**

In the signature section, there are eight lines that need to be completed. Below is an excerpt of the EDI Enrollment Form. Complete each line on the form per the instructions.

<div style="display: flex; justify-content: space-between;"> Provider's Name Telephone Number </div>	<p>Print the name and telephone number of the provider/facility.</p>
<div style="display: flex; justify-content: space-between;"> Medicare Provider/Group Number </div>	<p>Print the billing provider number. If the provider/facility has a group number, print the group number.</p>
<div style="display: flex; justify-content: space-between;"> Title </div>	<p>If the provider's name is the name of an individual (refer to "Provider's Name" line), print the title of that individual.</p>
<div style="display: flex; justify-content: space-between;"> Address </div>	<p>Print the address of the provider's facility/office.</p>
<div style="display: flex; justify-content: space-between;"> City/State/Zip </div>	<p>EDISS prefers the signature of the provider as the authorized signature. If the provider's signature is not available, EDISS will accept the signature of someone from the facility holding a management position or higher. If the provider/facility has been assigned a group number, EDISS requires the signature of the individual who has the authority to enter into contracts on behalf of the group. An original signature is required, and blue ink preferred.</p>
<div style="display: flex; justify-content: space-between;"> Authorized Signature </div>	<p>Print the title of the person who signed the "Authorized Signature" line.</p>
<div style="display: flex; justify-content: space-between;"> Title </div>	<p>Print the date of completion of this form.</p>
<div style="display: flex; justify-content: space-between;"> Date </div>	

To avoid any interruptions in your ability to exchange data with EDISS, mail **BOTH** first and second pages of the completed EDI Enrollment Form to:

**EDI Support Services
PO BOX 9319
Fargo, ND 58106-9319**

Electronic Data Interchange (EDI) Enrollment Form

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' contractors.

A. The Provider Agrees:

1. That it will be responsible for all Medicare claims submitted to CMS 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 contractors, 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 contractor 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-signed unique identifier number of the provider on each claim electronically transmitted to the contractor.
10. That the CMS-assigned unique identifier number constitutes the provider's legal electronic signature and an assurance by the provider that services were performed as billed.
11. That it will use sufficient security procedures 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 contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).
14. That it will research and correct claim discrepancies.
15. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

