

## HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 3-4 weeks.

## WHAT FORM(S) SHOULD I COMPLETE?

- If you do not currently submit electronically to Medicare FL:
  - EDI Enrollment Form
- If you already submit electronically, and are simply changing clearinghouses:
  - EMC Change of Information Form

## WHERE SHOULD I SEND THE FORMS?

- The original forms must be sent to:  
Medicare EDI  
P.O. Box 44701-14T  
Jacksonville, FL 32231-4071

## WHAT PROVIDER NUMBER DO I USE?

- NPI Number
- Tax ID Number
- Medicare Part B PTAN Provider Number

## WHO CAN SIGN THE FORMS?

- The Provider if a solo
- The President, or CEO or owner of the group or corporation

## HOW DO I CHECK STATUS?

- Call 1-888-670-0940
- Ask if Provider ID has been linked with Submitter ID P4888 for Office Ally

## **NOTE TO MY CLIENTS PLUS USERS:**

Once you have confirmed with the insurance payor that your provider number is linked to Office Ally, please fax the following information to My Clients Plus at 888-653-7115.

- **My Clients Plus**
- **Provider/Practice Name as pre-enrolled with the insurance payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement “I have verified my provider ID has been linked to Office Ally with the Insurance Payor”.**
- **Provider email address where you can be notified of setup completion.**

For Noridian Pre-Enrollments Please Also Include:

- **Submitter number**



## MEDICARE Electronic Data Interchange

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### General Completion Instructions For EMC Change Of Information Form

A signed EDI Enrollment Form must be submitted before a provider may begin to submit EDI transactions for the first time.

We highly recommend you take this opportunity to also enroll to receive your remittance advices electronically for even greater efficiency. A few advantages of receiving electronic remittances include: faster communication and payment notification, the ability to access data in a variety of formats through free, Medicare-supported software, and in some cases faster account reconciliation through electronic posting. Contact your software support vendor to ensure your software supports the electronic remittance advice. To enroll, complete the **Electronic Data Request (EDR) Form** available for download from our Web site [www.fcso.com](http://www.fcso.com) and select Electronic Services.

**Please review the completion instructions carefully as the type of change requested determines what information is required. If all of the required information is not provided, the form will be returned for the additional information.**

#### Section A: Selection of a Type of Change is required.

**Add a provider to an existing Submitter:** This will add a provider to an existing submitter for electronic claim submission. When requesting to add a provider, complete Sections B: 1-8 and C: 1.

**Delete a provider from an existing Submitter:** This will remove a provider from an existing submitter relationship for electronic claims submission. When requesting to delete a provider from a submitter, complete Sections B: 1-8 and C: 1.

**Delete Submitter Number:** Indicate the submitter number you wish to delete entirely from our Medicare system. Please complete Section C: 1-7.

**Change of Submitter Address:** Indicate the updated submitter address information. Complete Section C: 1-7. This form cannot be used to update a provider's address. For information about changing a provider's address, please contact the Provider Contact Center. To obtain the appropriate Provider Contact Center phone number, please visit [www.fcso.com](http://www.fcso.com), select Electronic Services and look in the Popular Links section for contact telephone numbers.

**Change of Submitter Contact Person:** Indicate the name of the new contact representative for the submitter. Complete Section C: 1 and 5.

**Email Address:** Indicate submitter's new email address. Please complete Section C: 1 and 2. Make sure that the Email information provided is legible.

#### Section B: Provider Information – All fields are required when this section is required (refer to Section A).

1. **Provider Name:** Print the name of the billing provider, Supplier/PA group/Clinic/Hospital.
2. **Provider Address:** Indicate the provider's physical or pay to address.
3. **City/State/ZIP:** Indicate the city/state/ZIP for the provider, Supplier/PA group/Clinic/Hospital.
4. **National Provider Identifier (NPI):** Indicate the billing provider's NPI.

5. **Tax Identification/SS Number:** Indicate the billing provider's tax identification number. If you do not have a tax identification number, indicate the billing provider's Social Security Number.
6. **Name of Person Requesting this Change:** Please print the name of the person requesting the change.
7. **Signature of Provider or Authorized Party for The Provider:** The signature of the provider or authorized party for the provider is required. When the provider is using a third party, e.g., clearinghouse, billing service, to exchange EDI transactions, the provider's signature serves as authorization for the third party to act on behalf of the provider for the indicated EDI transaction(s). In such cases the provider is required to have on file, an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. **A representative from a billing service or clearinghouse is not authorized to sign on behalf of the provider.**
8. **Effective Date:** Effective date on which the provider, Supplier/PA group/Clinic/Hospital will begin, change, or discontinue using a billing service, clearinghouse or other third party.

**Section C: Submitter Information** - All Fields Are Required Unless Indicated Otherwise. Conditional fields are required based on the selection in Section A.

1. **Submitter Number:** Indicate the submitter number for which the requested change applies.
2. **Submitter Name of Company** (Conditional): Indicate the name of the submitter.
3. **Submitter Address** (Conditional): Indicate the submitter address.
4. **City/State/ZIP** (Conditional): Indicate the submitter city, state and ZIP code.
5. **Contact Person** (Conditional): Indicate the name of the person to contact regarding this application.
6. **Telephone** (Conditional) **/Fax Number** (Optional): Indicate the submitter telephone/fax number.
7. **Effective Date:** Effective date of the submitter number deletion.

**Attention:** The submitter is required to notify Medicare EDI in writing in advance of any changes impacting their use of EDI and the effective date of such change. Medicare EDI must be notified if the provider will begin, change, or discontinue using a billing service, clearinghouse, or other third party, as well as of any changes related to electronic transactions the provider uses.



**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:** P4888
2. **Submitter name of company** (Conditional): Office Ally
3. **Submitter address** (Conditional): P.O. Box 872020
4. **City/State/ZIP** (Conditional): Vancouver, WA 98687
5. **Contact person** (Conditional): Customer Service
6. **Telephone No** (Conditional): 866-575-4120 **Fax No** (Optional): 360-896-2151
7. **Effective Date** (Conditional): \_\_\_\_\_

Fax or mail completed form to:	Medicare EDI	Medicare EDI
Fax: 904-361-0470	Attn: Enrollment Team – 14T	Attn: Enrollment Team – 14T
Phone: 1-888-670-0940, option 4	P.O. Box 44071	532 Riverside Avenue
	Jacksonville, FL 32231-4071	or Jacksonville, FL 32202-4918