

MEDICARE GEORGIA PART B PRE-ENROLLMENT INSTRUCTIONS – 00511



Cahaba GBA has changed their enrollment process. They now require all enrollments to be completed online. Each form is accompanied by a fax cover sheet with a unique barcode which MUST accompany the form when submitted via fax to Cahaba GBA.

HOW LONG DOES PRE-ENROLLMENT TAKE?

- It takes approximately 10 business days to complete the enrollment process. Cahaba GBA will notify the provider.

WHERE SHOULD I SEND THE FORM?

- Fax the form to Cahaba EDI at (205) 402-9200

HOW DO I ENROLL / WHAT FORM DO I COMPLETE?

1. Open your internet browser and go to:
http://www.cahabagba.com/part_b/forms/PartBEDIAApplication.pdf
2. Complete the Electronic Data Interchange (EDI) Application as instructed below:

General Information: Complete with information provided below

State: Georgia Alabama Mississippi Tennessee

I am requesting to (Select one from dropdown):

Additional Options: Request Electronic Remits PPTN Access
 Perform 276/277 (Batch Claim Status)

I will be sending my claims and retrieving remits (Select one from dropdown):

List submitter ID

Provider Information: Complete with Provider/Facility information

Group, Provider, or Facility Name:

Mailing/Pay-To Address:

City: State: Zip Code:

Contact Name: E-Mail Address:

Phone Number: Fax Number:

PTAN, NPI, & Tax ID (EIN) Numbers: (The Group PTAN and NPI are required if applicable. For a solo practice, please list the individual PTAN and NPI) Complete with Provider/Facility information

Group PTAN: Group NPI: EIN:

Method of Interchange:

FREE PC-ACE Pro 32 Software SKIP

- Using an existing submitter ID
- Reactivating your submitter ID

Sending direct to Medicare using software from a vendor or using All-Payer Version of PC-ACE Pro 32 SKIP

- Using an existing submitter ID
- Reactivating your submitter ID

Vendor Name: Phone Number:

Mailing Address:

City: State: Zip Code:

Contact Name: E-Mail Address:

Sending through a Billing Service/Clearing House (3rd Party) Complete with information provided below

Billing Service/Clearinghouse Name:

Mailing Address: Phone Number:

City: State: Zip Code:

Contact Name: E-Mail Address:

Professional Provider Telecommunications Network (PPTN): (Please indicate connectivity vendor below) SKIP

IVANs Vision Share Other:

System Access Requests, please list complete names of all users you are requesting access for (Requests to add users to multiple PTAN's will have to come on separate applications): SKIP

First Name	Middle Name	Last Name	EDC ID	PPTN ID	PIN	Request
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Read Page 6 – Cahaba GBA Agreement](#)

Signature: (By signing this document you are stating that you are authorized to sign on behalf of the indicated party and have read and agree to the foregoing provisions and acknowledge same) Complete this section with provider/facility information

Provider's Name Title

Mailing Address:

City: State: Zip Code:

Group PTAN: Group NPI: Submitter ID (if applicable)

Printed Name Signature: _____

3. Print the entire form, including the cover sheet (page 1). Sign where requested & fax the form the Cahaba GBA EDI Department at (205) 402-9200. You MUST include the cover sheet provided by Cahaba GBA with this submission or your application will be denied.

HOW DO I CHECK STATUS?

- Call 866-582-3253 and ask if your provider number has been linked to Office Ally.

WHAT PROVIDER NUMBER DO I USE?

- Medicare PTAN Group Number
- User one (1) provider number per form
- If you are a group, list only your group name and group number. Do one form for each group number you have.

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**