

MEDICARE NEW HAMPSHIRE PRE-ENROLLMENT INSTRUCTIONS - 14302



HOW LONG DOES PRE-ENROLLMENT TAKE?

- Approximately 3 weeks

WHAT FORM(S) SHOULD I DO?

- EDI Enrollment Form
- EDI Profile
- Provider/Submitter Agreement

WHERE SHOULD I SEND THE FORMS?

- Fax the forms to NHIC, Corp at 781-741-3523

WHO CAN SIGN THE FORMS?

- The provider or authorized designator can sign the form

OBTAINING APPROVALS: HOW DO I CHECK STATUS?

- Call 866-801-5304 and ask if your provider number has been linked to Office Ally's submitter ID 7166.

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 – NHIC, CORP.
ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or 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 signature, 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 six years, three months after the bill is paid;
9. That it will affix the CMS-assigned 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 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 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 Social Security Act (the Act));

14. That it will research and correct claim discrepancies;
15. That it will notify the CMS contractor within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services will:

1. Transmit to the provider an acknowledgement of claim receipt;
2. Affix the intermediary/carrier 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 contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor 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 contractors 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 contractor sells directly, indirectly, or by arrangement;
6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

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 CMS or the contractor. 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. (**Original signature required, PLEASE USE BLUE INK*)

Provider/Supplier Business Name _____

Address _____

City/State/Zip _____

Signature (Authorized Rep)* _____

Printed Name (Authorized Rep) _____

Title _____

Date _____

Submitter Name/Billing Agent Office Ally

Software Vendor Proprietary Software

Submitter ID 7166

Vendor Phone Number 866-575-4120

PIN/PTAN Number _____

NPI Number _____

NHIC, Corp	
Document Name: EDI Profile Form	Doc. Number: FRM-EDI-0004
Release Date: 10/28/2009	Version: 32.0

EDI PROFILE FORM

Required, complete this form, MAIL it with Signature Page, to receive electronic remittance* include number 2 or 3

- 1) EDI Enrollment Form Signature Page (required for new enrollments; original signature of Owner, President or CEO required)
- 2) Electronic Remittance Advice (ERA) Enrollment Form (ERA to you when submitting your claims directly to NHIC, Corp.)
- 3) or, Provider/Submitter Agreement (ERA to the billing agency/clearing house submitting Medicare claims on your behalf)

Fax all your applicable completed forms to the NHIC, Corp: FAX: 781-741-3523

Or you can mail your form to:

NHIC, Corp.- New England
 Attn: EDI Department
 PO Box 9104
 Hingham, MA 02044-9104
 Our toll free number is: 1-877-386-1056

PRINT

PROVIDER OFFICE PRACTICE INFORMATION (Physical location where you PERFORM services)			
STATE: _____	PART B: <input type="checkbox"/>	NPI #:	PTAN #:
NAME:			DATE:
ADDRESS:		EMAIL:	
CITY:	STATE:	ZIP:	
CONTACT (FULL NAME):	PHONE:	FAX #:	
CONTACT (FULL NAME):	PHONE:	FAX #:	
SUBMITTER INFORMATION (Who will submit claims)			
<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> CHANGE SUBMITTER	<input type="checkbox"/> ADD SUBMITTER (Duel)	<input type="checkbox"/> CHANGE FILE TRANSFER TYPE
PLEASE CHECK THE APPROPRIATE BOX	PROVIDER: <input type="checkbox"/> * ERA see below	BILLING AGENT: <input type="checkbox"/>	CLEARING HOUSE: <input type="checkbox"/>
File Transfer Transmission Type	<input type="checkbox"/> - MODEM	<input type="checkbox"/> - SFTP Via IVANS	<input type="checkbox"/> - SFTP Via Vision Share
NAME:		SID# (Submitter ID#):	
ADDRESS:		EMAIL ADDRESS:	
PLEASE SUPPLY AN ACCOUNT / REFERENCE NUMBER WHICH WILL BE INCLUDED IN THE EMAIL CONFIRMATION :			
CITY:	STATE:	ZIP:	
CONTACT (FULL NAME):	PHONE:	FAX #:	
CONTACT (FULL NAME):	PHONE:	FAX #:	
SOFTWARE INFORMATION (The type of software/operating system)			
COMPANY:			
CONTACT (FULL NAME):		PHONE:	
NAME OF SOFTWARE:		OPERATING SYSTEM:	
ELECTRONIC REMITTANCE ADVICE (ERA) (Electronic version of paper Standard Provider Remittance (SPR))			
*An Electronic Remittance Advice (ERA) file can allow you to automatically post to the accounts receivable module if your practice management software allows for that capability. If your software is capable and you wish ERA, choose the ERA file format check box below.			
NOTE: If a billing agency or clearinghouse will receive remittance on your behalf, the "Provider/Submitter Agreement" MUST be submitted with this form and it MUST be signed by the provider AND the billing agency/clearinghouse representative, in order to add ERA.			
For paper remittance, skip the section below or simply check . <input type="checkbox"/> I WISH TO CONTINUE RECEIVING PAPER SPR's			
YES, SEND UNCOMPRESSED ERA FILES (UNZIPPED) <input type="checkbox"/> <u>OR</u> YES, SEND COMPRESSED ERA FILES (ZIPPED) <input type="checkbox"/>			
(Authorized Rep) Provider/Supplier's Signature to receive ERA:			
Take advantage of the FREE Medicare Remit Easy Print (MREP) software now available for viewing and printing the HIPAA compliant ERA! Download the MREP software available at http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp .			

PRINT

MEDICARE PART B Electronic Data Interchange-Provider/Submitter Agreement

SECTION 1 – BILLING AGREEMENT CHANGE REQUEST

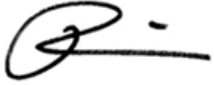
To be completed by **Medicare Part B Provider** if an entity is submitting claims on behalf of the provider.

Date: _____	NPI #: _____	*PIN/PTAN #: _____
Provider Name: _____		
Physical Practice Address: (<i>Where services physically performed</i>)		
Street Address: _____		
City/State/Zip: _____		
Contact Name: _____		
Phone Number: _____		
I, _____,	+	_____ Title: _____
(PROVIDER PRINT NAME)		(PROVIDER SIGNATURE)+
Authorize; _____	Submitter ID: _____	
(SUBMITTER NAME)		
to submit claims directly to NHIC, Corp. - Medicare B electronically, and request the above provider number be **removed from Submitter ID(s): _____.		
<p>+ Authorization signature must be from the President, CEO or Owner only. **A PIN/PTAN # (*provider number) may only be linked to one submitter number. Therefore, this form will not be processed if your provider number is linked to more than one submitter number and you do not indicate what submitter number(s) to remove.</p>		

This form is only accepted if a current – original – EDI Enrollment Form is on file with the NHIC Corp office that processes your Medicare Part B claims.

SECTION 2 – REMITTANCE AGREEMENT

To be signed by Billing Service or Clearinghouse only if you request to receive an Electronic Remittance File on behalf of a Medicare Part B Provider.

A billing service or clearinghouse may accept remittance files on behalf of a provider(s), but the billing service or clearinghouse is PROHIBITED from viewing, storing, modifying or reporting the data for its own use.	
 _____	Title: _____
Billing Service/Clearinghouse Rep: (PRINT NAME)	Billing Service/Clearinghouse Rep: (SIGNATURE)
The signature on this form signifies your agreement with this requirement. This document must be signed by a representative from the Billing Service or Clearinghouse.	
All Medicare beneficiary specific information is confidential and subject to the requirements of 1106(a) of the Social Security Act.	

NHIC, Corp. - New England
PO Box 9104
Hingham, MA 02044
Attn: EDI Department
FAX 781-741-3523