

# MEDICARE MAINE PRE-ENROLLMENT INSTRUCTIONS - 14102



## HOW LONG DOES PRE-ENROLLMENT TAKE?

- Approximately 3 weeks

## WHERE SHOULD I SEND THE FORMS?

- Fax the forms to NHIC Corp. at 781-741-3523, or;
- Mail the forms to:  
NHIC Corp. – New England  
PO Box 9104  
Hingham, MA 02044  
Attn: EDI Department

ALL FORMS CAN BE FAXED – PLEASE DISREGARD NOTICE ON THE EDI ENROLLMENT AGREEMENT FORM.

## WHO CAN SIGN THE FORMS?

- Provider, Owner, President/CEO, or authorized representative may sign the forms.

## WHAT FORM SHOULD I DO?

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

## 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.
- Once you have been linked you MUST contact Office Ally at 866-575-4120 option 1 to inform them of the approval BEFORE submitting any claims for electronic transmission.

## WHAT PROVIDER NUMBER DO I USE?

- NPI #
- PIN/PTAN#

## **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**

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Document Name: EDI Profile Form	Doc. Number: FRM-EDI-0004
Release Date: 03/22/2011	Version: 5.0

## EDI PROFILE and AUTHORIZATION FORM

- 1: Complete this entire form, with the appropriate Signatures**  
**2: First time submitters must include the EDI enrollment forms** (required for new enrollments; original signature of Owner, President or CEO required)

**Fax all your applicable completed forms to the NHIC, Corp:**

**FAX: 781-741-3523**

Mailing Instructions and additional contact information is listed on the final page of this form.

SECTION 1: PROVIDER OFFICE PRACTICE INFORMATION (Physical location where you PERFORM services)			
STATE:	PART B: <input type="checkbox"/>	<input checked="" type="checkbox"/>	NPI #:
PROVIDER/SUPPLIER NAME: (As enrolled with Medicare MAC J14) :			PTAN #:
ADDRESS:		EMAIL:	
CITY:	STATE:	ZIP:	
CONTACT (FULL NAME):	PHONE:	FAX #:	
CONTACT (FULL NAME):	PHONE:	FAX #:	

SECTION 2: SUBMITTER INFORMATION			
2A: What type of Action are you making today			
<input type="checkbox"/> NEW ENROLLMENT	<input type="checkbox"/> CHANGE SUBMITTER	<input type="checkbox"/> ADD SUBMITTER (dual)	<input type="checkbox"/> CHANGE ERA RECIEVER
			<input type="checkbox"/> CHANGE FILE TRANSFER TYPE Complete section 2C
2B: Who will submit claims			
PLEASE CHECK THE APPROPRIATE BOX	PROVIDER: <input type="checkbox"/>	BILLING AGENT: <input type="checkbox"/> Sign Section "4A "	CLEARING HOUSE: <input checked="" type="checkbox"/> Sign Section " 4A "
2C: File Transfer Transmission Type			
<input type="checkbox"/> - MODEM			
<input type="checkbox"/> - SFTP VIA ABILITY	<input type="checkbox"/> - SFTP VIA CLAIMSHUTTLE	<input checked="" type="checkbox"/> - SFTP VIA ECC TECHNOLOGIES	<input type="checkbox"/> - SFTP VIA IVANS, INC
2D: Submitter AND/OR Receiver Information			
NAME: Office Ally		SID# (Submitter ID#): 7166	
ADDRESS: PO Box 872020		EMAIL ADDRESS: info@officeally.com	
PLEASE SUPPLY AN ACCOUNT / REFERENCE NUMBER WHICH WILL BE INCLUDED IN THE EMAIL CONFIRMATION :			
CITY: Vancouver		STATE: Washington	ZIP: 98687
CONTACT (FULL NAME): Customer Service		PHONE: (866) 575-4120 opt. 1	FAX #:(360) 896-2151
2E: SOFTWARE INFORMATION (The type of software/operating system)			
<input type="checkbox"/> - I am a Medicare Provider billing Medicare directly on my own and want to use "STRATFORD FREE SOFTWARE "			
COMPANY: Office Ally			
CONTACT (FULL NAME): Customer Support		PHONE: (866) 575-4120 opt.1	
NAME OF SOFTWARE: Proprietary Software		OPERATING SYSTEM:N W2K & W2K3	

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**SECTION 3: ELECTRONIC REMITTANCE ADVICE (ERA)**

**3A: ERA (Electronic version of paper Standard Provider Remittance (SPR))**

**YES, I want to receive my Remittance Advices in the fastest way possible.**

\*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.

**YES, SEND UNCOMPRESSED ERA FILES (UNZIPPED)**    OR     **YES, SEND COMPRESSED ERA FILES (ZIPPED)**

**No, Continue to send paper remittances through the standard US Postal system. (continue to section 4)**

**3B: If YES, Who will receive your remittances advises:**

**Provider in Section 2:**  
 (Authorized Rep) Provider/Supplier's Signature to receive ERA: \_\_\_\_\_

**Billing Agent/Clearing House in Section II:**  
**Please Complete Section 4B**

**Separate Remittance Receiver other than listed in Section 2:**  
**Please Complete Section 3C**

**Section 3C: Separate Remittance Agreement Statement.**

Electronic Data Interchange-Provider/Separate Remittance Agreement

NPI #: \_\_\_\_\_ PIN/PTAN #: \_\_\_\_\_ Date: \_\_\_\_\_

Provider/ Supplier Name: \_\_\_\_\_  
 (As enrolled with Medicare)

Street Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

I, \_\_\_\_\_ + \_\_\_\_\_  
 (**Authorized Provider Printed Name**), (**Authorized Provider Signature**)

**Authorize Medicare Part B remittance files from**

Sender (Sender Name): \_\_\_\_\_

Sender Submitter Number: \_\_\_\_\_, **to be delivered on my behalf TO:**

Receiver (Receiver name): \_\_\_\_\_

Receiver Submitter ID (submitter number the remittance will go to): \_\_\_\_\_

Effective date: \* \_\_\_\_\_ \*If the effective date is blank, this transaction will be effective the date it is received.

File Transfer Transmission Type:  Modem  SFTP Via Ivans  SFTP Via Vision Share

**MUST BE SIGNED BY REMITTANCE FILE RECEIVER**

*A Remittance Receiver, Billing service or Clearinghouse may accept remittance files on behalf of a provider(s), but the Remittance Receiver, Billing Service or Clearinghouse is **prohibited** from viewing, storing, modifying or reporting the data for its own use.*

*The signature on this form signifies your agreement with this requirement.*

\_\_\_\_\_  
**(Signature: Remittance Receiver/Billing Service/Clearinghouse Representative)**

\_\_\_\_\_  
 (Printed Representative's Name) (Business Name)

Contact: \_\_\_\_\_

Address: \*Street: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Email address: \_\_\_\_\_

All Medicare beneficiary specific information is confidential and subject to the requirements of 1106(a) of the Social Security Act.

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**SECTION 4: Additional Agreements**

**Section 4A**                      **837: Electronic Data Interchange-Provider/Submitter Agreement**  
 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: (*Where services physically performed*)

Street Address: \_\_\_\_\_

City/ State/Zip: \_\_\_\_\_

Contact Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_

I, \_\_\_\_\_ + \_\_\_\_\_ Title: \_\_\_\_\_

(PROVIDER PRINT NAME)                      (PROVIDER SIGNATURE)

Authorize; Office Ally \_\_\_\_\_ Submitter ID: 7166 \_\_\_\_\_

(SUMITTER NAME)

to submit claims directly to NHIC, Corp. - Medicare B electronically, and request the above provider number be  
 \*\*removed from Submitter ID(s): \_\_\_\_\_


All Medicare beneficiary specific information is confidential and subject to the requirements of 1106(a) of the Social Security Act

**Section 4B**                      **835: Electronic Data Interchange-Provider/Receiver 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 or  
 clearinghouse is **PROHIBITED** from viewing, storing, modifying or reporting the data for its own use.

Office Ally \_\_\_\_\_

(Billing Service/Clearinghouse Business Name)

 \_\_\_\_\_ Title: President & CEO

Billing Service/Clearinghouse Authorized Rep:

(SIGNATURE)  
 Brian P. O'Neill \_\_\_\_\_

Billing Service/Clearinghouse Authorized Rep

(PRINT NAME)

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

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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/AccessToDataApplication/02\\_MedicareRemitEasyPrint.asp](http://www.cms.hhs.gov/AccessToDataApplication/02_MedicareRemitEasyPrint.asp)

**Fax 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

Should you need assistance with any portion of this enrollment form, please do not hesitate to contact the EDI Support Helpdesk at:

1-877-386-1056  
Monday – Friday, 8:00am – 4:00pm

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