

MEDICARE NEW HAMPSHIRE PRE-ENROLLMENT INSTRUCTIONS - 14302



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**

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

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' FIs, Carriers, RHHIs, A/B MACs or CEDI:

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 FIs, Carriers, RHHIs, A/B MACs, DME MACs or CEDI 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 FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS 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 (submitter identifier) of the provider on each claim electronically transmitted to the FI, Carrier, RHHI, A/B MAC, CEDI, or other contractor if designated by CMS
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 FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS shall not be used by agents, officers, or employees of the billing service except as provided by the FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI (in accordance with §1106(a) of Social Security Act (the Act) (See section 40.1.2.2 below for a complete reference to Medicare's security requirements);
14. That it will research and correct claim discrepancies;
15. That it will notify the FI, Carrier, RHHI, A/B MAC, CEDI, or other contractor if designated by CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form (See section 40.1.2.2 below for a complete reference to Medicare's security requirements).

B. The Centers for Medicare & Medicaid Services will:

1. Transmit to the provider an acknowledgement of claim receipt;
2. Affix the FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI or other contractor if designated by CMS 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 FIs, Carriers, RHHIs, A/B MACs, CEDI, or other contractors if designated by CMS 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 sold directly, indirectly, or by arrangement by the FI, Carrier, RHHI, A/B MAC, CEDI, or other contractor if designated by CMS;
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 the FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI, or other contractor if designated by CMS. 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 certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with (MAC name) on my behalf.

Provider/Supplier Business Name _____

Address _____

City/State/Zip _____

Signature (Authorized Rep) _____

Printed Name (Authorized Rep) _____

Title _____

Date _____

Submitter Name/Billing Agent _____

Software Vendor _____

Submitter ID _____

Vendor Phone Number _____

PIN/PTAN Number _____

NPI Number _____

NHIC, Corp	
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: New Hampshire	PART B: <input checked="" type="checkbox"/>	NPI:	PTAN #:
PROVIDER/SUPPLIER NAME: (As enrolled with Medicare MAC J14) :			DATE:
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: WA	ZIP: 98687
CONTACT (FULL NAME): Customer Support		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:R 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

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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