

# MEDICARE TEXAS (TRAILBLAZERS) PRE-ENROLLMENT INSTRUCTIONS – MR085



## HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 5 business days after receipt.

## WHAT FORM(S) SHOULD I COMPLETE?

- ✓ EDI Provider Information Form
- ✓ Enrollment Agreement

## WHO CAN SIGN THE FORM(S)?

- The Provider must sign the form.

## WHERE SHOULD I SEND THE FORM(S)?

- The form(s) must be mailed to:  
TrailBlazer Health Enterprises, LLC  
EDI Operations, AG-507  
P.O. Box 100249  
Columbia, SC 29202-3249

## HOW DO I CHECK STATUS?

- Call 866-749-4302 and have your Medicare Provider Number and/or NPI Number ready.
- Ask if your Provider Number and/or NPI Number have been linked to Office Ally's submitter# RR3426.
- Once you have received notification that you have been linked you MUST contact Office Ally at 866-575-4120, option 1 to notify us of the approval BEFORE submitting claims for electronic transmission.

## WHAT PROVIDER NUMBERS DO I USE?

- NPI Number
- Medicare Provider Number

## **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**

Dear Provider, Vendor, Clearinghouse or Billing Service:

Thank you for your interest in Electronic Media Claims (EMC). Enclosed is a summary of the available electronic claims services for Medicare Part A/B providers. Also enclosed are the necessary applications, enrollment forms and instructions for their completion.

**Section 1 - General Electronic Data Interchange (EDI) Enrollment Documents** – Contains the **required** enrollment documents that must be completed, signed and returned to our office prior to initiation of electronic claims submission or inquiry.

**Section 2 - Direct Data Entry (DDE) for Part A** – Contains connectivity information regarding claim entry via on-line DDE.

**Section 3 - Free Billing Software**

**Section 4 - Testing Requirements**

We are committed to making your transition to EMC as smooth as possible. If you have any questions regarding the information contained in this package, please feel free to contact the TrailBlazer Health Enterprises<sup>®</sup> EDI Technology Support Center toll free at (866) 749-4302.

### **Be Compliant: Take Control of Your Accounts Receivable**

Sign up today to receive your remittances electronically. Download and print your remittances more quickly. CMS is focused on increasing the number of providers who receive their remittances electronically and on decreasing the printing and mailing costs associated with hard copy remittances. Complete your forms today!

### **Important Note on Staying Up-To-Date Online**

Register on the TrailBlazer<sup>SM</sup> Web site at [www.trailblazerhealth.com](http://www.trailblazerhealth.com) to receive EDI news electronically. By selecting “Listserv” (which displays at the top of all pages) and completing a user profile, you will be notified via e-mail when new or important EDI information is added to the Web site. If you have already registered, please ensure your profile has been updated for all new applicable EDI categories.

## SECTION 1 – GENERAL EDI ENROLLMENT DOCUMENTS

### EDI Provider Information Form

The EDI Provider Information Form is used for initial EDI set up. The information on this form is also used to verify requester information submitted on additional EDI applications. Please follow the instructions carefully when completing the form. Incomplete forms will be returned to the applicant, thus delaying processing.

The name of the provider (an authorized officer's name) must be printed in the space provided and that authorized officer's title and signature must also be included. The name and signature **must match** what is submitted on the EDI Agreement Form.

Providers who submit claims directly from their office will be assigned a Submitter ID. Providers are not permitted to share their personal EDI access number (submitter ID) or password with:

- Any billing agent, clearinghouse/network service vendor.
- To anyone on their staffs who has no need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility or to determine the status of a claim.
- Any non-staff individual or entity.

The EDI submitter ID and password act as an electronic signature; therefore, the provider would be liable if any entity performed an illegal action while using that EDI submitter ID and password. Likewise, a provider's EDI submitter ID and password are non-transferable, meaning they may not be given to a new owner of the provider's operation. New owners must obtain their own EDI submitter ID and password.

### Medicare Electronic Data Interchange Enrollment Agreement

The EDI Enrollment Agreement should be submitted when enrolling for electronic billing. It should be reviewed and signed **only** by the provider to ensure each is knowledgeable of the enrollment request and the associated requirements:

- If the submitter will be submitting for multiple providers, each provider whose claim data will be submitted must complete this form.
- The entire form must be read carefully and then dated with the day, month and year.
- The name of the provider (an authorized officer's name) must be printed in the space provided and that authorized officer's title and signature must also be included. The name and signature **must match** what is submitted on the EDI Provider Information Form.
- When completed, **all three pages** of the properly executed **EDI Enrollment Agreement** must be returned **with** the EDI Application form.

### EDI Vendor / Billing Service / Clearinghouse ID Request Form

The purpose of this form is to establish a Vendor / Billing Service / Clearinghouse ID for software vendors, clearinghouses and billing services to submit claim files, or retrieve response reports. Please follow the instructions carefully when completing the form. Incomplete forms will be returned to the applicant, thus delaying processing. The information submitted on this form will be included in the Certified Vendor Directory once you have successfully passed the testing requirements (see Section 3 – Testing Requirements).

Submitters are responsible for notifying Medicare if any information on this form changes, including change of software being used to submit files to TrailBlazer.

## Additional Information for Providers

Providers who have contracted with a third party (clearinghouse/network service vendor or a billing agent) are required to have that third party sign an agreement in which they agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. These agreements are not to be submitted to Medicare, but are to be retained by the providers.

Providers are obligated to notify Medicare by hard copy of:

- Any changes in their billing agents or clearinghouses.
- The effective date they will discontinue using a specific billing agent or clearinghouse.
- If they want to begin using additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouses begin to use alternate software. The clearinghouses are responsible for notification in this instance.

**Note:** The binding information in an EDI Enrollment Form does not expire if the person who signed the form for a provider is no longer employed by the provider.

## The EDI Application Process for Providers

**Step 1:** Complete the EDI application.

**Step 2:** Complete and sign the Medicare Electronic Data Interchange Enrollment Agreement. The Medicare provider must complete and sign this form.

**Step 3:** Complete documents and mail to the following address:

MAILING ADDRESS	DELIVERY ADDRESS
TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 P.O. Box 100249 Columbia, SC 29202-3249	TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 Building One 2300 Springdale Drive Camden, SC 29020-1728

**Step 4:** Retain the completed forms for your records.

## The EDI Application Process for Vendors, Billing Services and Clearinghouses

**Step 1:** Complete the TrailBlazer EDI Vendor / Billing Service / Clearinghouse ID Request Form.

**Step 2:** Mail form to the following address:

MAILING ADDRESS	DELIVERY ADDRESS
TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 P.O. Box 100249 Columbia, SC 29202-3249	TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 Building One 2300 Springdale Drive Camden, SC 29020-1728

Processing an EDI application will take **five business days** from the date of receipt. When processing is complete, you will receive a notification by e-mail (primary communication method), fax or mail. New electronic submitters and software vendors will be informed of any testing requirements.

## EDI PROVIDER INFORMATION FORM

**Please retain a copy of this completed form for your records. You must submit a completed EDI application form when submitting additional EDI forms.**

The field descriptions listed below will aid in properly completing the application. Please follow these instructions closely. The Medicare Electronic Data Interchange Application is required. The Multiple Provider List should be used if you are listing additional providers on your application.

Form Field Name	Instructions for Field Completion
<b>1. Provider Data</b>	<ul style="list-style-type: none"> <li>• Complete the date, provider’s name, address, primary contact, phone, fax and e-mail address.</li> <li>• Indicate the National Provider Identifier (NPI) and Provider Number.</li> <li>• Indicate the Submitter ID if you are a direct submitter and are making an update.</li> <li>• EDI Transaction: Please indicate if you are enrolling for Electronic Claim Submission and/or Electronic Remittances.</li> <li>• Select the EDI Transaction requested.</li> <li>• The name of the provider (an authorized officer’s name) must be printed in the space provided and that authorized officer’s title and signature must also be included. The name and signature <b>must match</b> what is submitted on the EDI Agreement Form.</li> <li>• Action Requested: Please indicate appropriate request below:                             <ul style="list-style-type: none"> <li>• Provider is Submitter – Provider submits claims directly from their office</li> <li>• Provider is with Billing Service/Clearinghouse</li> </ul> </li> </ul>
<b>2. EDI Software Vendor Data</b>	Indicate the name of the software vendor you will use for electronic claim submission to TrailBlazer. If you will use our free PC-ACE Pro32, write PC-ACE Pro32 in this field. If the vendor ID is known, enter the assigned ID; PC-ACE users may leave this field blank.
<b>3. EDI Billing Service/ Clearinghouse Data</b>	Indicate the name, primary contact, phone, fax and Submitter ID of the billing service or clearinghouse that will be communicating with TrailBlazer.



## EDI Provider Information Form

<b>1. Provider Data</b> (To be completed by provider)		Date:
Name:		
Address:		
City, State, ZIP:		
Primary Contact:		
Phone Number:		Fax Number:
E-mail Address:		
Please Check One: <input type="checkbox"/> Part A Provider <input checked="" type="checkbox"/> Part B Provider		
Please Check Applicable State: <input type="checkbox"/> CO <input type="checkbox"/> NM <input type="checkbox"/> OK <input checked="" type="checkbox"/> TX		
NPI (National Provider Identifier):		Provider Number:
Submitter ID (if available):		
<p><b>I certify that I am legally empowered to sign this form on behalf of the Legal Business Name identified on this form. I acknowledge that in signing this, I bind this company or unincorporated organization to notify the Medicare contractor in advance and in writing if changes have occurred to information reported in this form or if it is necessary to revoke any designations made in the form. I certify that the information I have supplied is accurate. As a Medicare provider/supplier, I understand that in signing this form I am responsible for payment of any fees for EDI services charged by a designated EDI submitter/receiver with whom I have elected to conduct business. I also understand that any acknowledgement, error reports, or query responses related to submitted transactions will be returned to any designated EDI submitter/receiver with whom I have authorized on this form and that Medicare contractors are not permitted to send duplicate copies of outbound transactions to my organization as well as to the designated EDI submitter/receiver.</b></p>		
Signature _____		Printed Name _____
Title _____		Date _____
Action Requested:		
<input type="checkbox"/> Provider is Submitter (Provider submits claims directly from their office)		
<input type="checkbox"/> Provider is with Billing Service/Clearinghouse (Section 3 must be completed)		
<b>2. EDI Software Vendor Data</b> (To be completed by vendor)		
Company Name: Office Ally		
Primary Contact: Wendy Coppin Customer Service		Phone: 866-575-4120 Opt 1
Vendor Code:		Fax: 360-896-2151
<b>3. EDI Billing Service/Clearinghouse Data</b> (To be completed by billing service/clearinghouse)		
Company Name: Office Ally		
Primary Contact: Wendy Coppin Customer Service		Phone: 866-575-4120 Opt 1
Submitter ID: RR3426		Fax: 360-896-2151

## **MEDICARE ELECTRONIC DATA INTERCHANGE ENROLLMENT AGREEMENT**

- A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers, MACs, or FIs:**
1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contactor 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 carriers, MACs, FIs or another contractor if so designated by CMS 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 signatures, 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 carrier, MAC, FI 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 6 years, 3 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 carrier, MAC, FI or other contractor if designated by CMS;

10. That the CMS-assigned unique identifier number (submitter identifier) or NPI 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 carrier, MAC or FI 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 carrier, MAC or FI (in accordance with §1106(a) of the Social Security Act (the Act));
14. That it will research and correct claim discrepancies;
15. That it will notify the carrier, MAC or FI or other contractor if designated by CMS within two business days if any transmitted data are received in an unintelligible or garbled form.

**B. The Centers for Medicare & Medicaid Services (CMS) agrees to:**

1. Transmit to the provider an acknowledgment of claim receipt;
2. Affix the FI/carrier/MAC 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's policies;
4. Ensure that no carrier, MAC, FI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, MAC, or FI, or from any subsidiary of the carrier, MAC, FI, other contractor if designated by CMS, or from any company for which the carrier, MAC, or FI has an interest. The carrier, MAC, FI, or other contractor if designated by CMS 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 carriers, MACs, FIs, 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 the carrier, MAC, FI, or other contractor if designated by CMS sells directly, or indirectly, or by arrangement;
6. Notify the provider within two business days if any transmitted data are received in an unintelligible or garbled form;

**Note:** 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 carrier, MAC, FI, 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 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.

Provider's Name: \_\_\_\_\_

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

\_\_\_\_\_

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

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

Authorized Signature: \_\_\_\_\_

By (Print Name): \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_ Medicare Provider Number \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

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Complete ALL fields above and mail entire agreement (three pages) with **original** signature to:

TrailBlazer Health Enterprises, LLC  
EDI Operations, AG-507  
P.O. Box 100249  
Columbia, SC 29202-3249