



Payor Agreement Cover Sheet

**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.

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

Title \_\_\_\_\_

Address \_\_\_\_\_

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

Signature \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Submitter Name/Billing Agent \_\_\_\_\_ Software Vendor \_\_\_\_\_

Submitter ID \_\_\_\_\_ Vendor Phone Number \_\_\_\_\_

Provider Number \_\_\_\_\_

## EDI PROFILE FORM

Please complete and **MAIL** with an:

- 1) EDI Enrollment Form (Original Signature Required)
- 2) Electronic Remittance Advice (ERA) Enrollment Form (required if receiving ERA and submitting claims direct to NHIC, Corp.)
- 3) Provider/Submitter Agreement (required if receiving ERA and submitting claims via a billing agency or clearing house) to the NHIC, Corp. office, that processes your Medicare Part B claims:

**NHIC, Corp. - California**  
 Attn: EDI Department  
 PO Box 2807  
 Chico, CA 95927

**NHIC, Corp.- New England**  
 Attn: EDI Department  
 PO Box 9104  
 Hingham, MA 02044-9104

PROVIDER OFFICE PRACTICE INFORMATION (Physical location where you PERFORM services)									
DATE:									
NAME:						MEDICARE B PROVIDER #:			
ADDRESS:				EMAIL ADDRESS:					
CITY:			STATE:			ZIP:			
CONTACT (FULL NAME):					PHONE:				
CONTACT (FULL NAME):					FAX #:				
SUBMITTER INFORMATION (Who will submit claims)									
PLEASE CHECK THE APPROPRIATE BOX			PROVIDER: <input type="checkbox"/>		BILLING AGENT: <input type="checkbox"/>		CLEARING HOUSE: <input type="checkbox"/>		
NAME:					SID# (Submitter ID#):				
ADDRESS:				EMAIL ADDRESS:					
CITY:			STATE:			ZIP:			
CONTACT (FULL NAME):					PHONE:				
CONTACT (FULL NAME):					FAX #:				
SOFTWARE INFORMATION									
COMPANY:									
CONTACT (FULL NAME):					PHONE:				
NAME OF SOFTWARE:					OPERATING SYSTEM:				
ELECTRONIC REMITTANCE ADVICE									
An Electronic Remittance Advice (ERA) file allows you to automatically post to your accounts receivable module of your practice management software. If your software allows for this capability and would like to take advantage of this feature, complete the check-off boxes below: <b>If a billing agency or clearinghouse will receive remittance on your behalf, the "Remittance Agreement" MUST also be submitted.</b>									
COMPRESSED (ZIPPED) <input type="checkbox"/> UNCOMPRESSED (UNZIPPED) <input type="checkbox"/>									
Take advantage of the <b>FREE Medicare Remit Easy Print (MREP)</b> software now available for viewing and printing the HIPAA compliant ERA! MREP information and the link to download the MREP software are available at <a href="http://www.medicarenhic.com/edi/download/mrepsoftware_1005.htm">http://www.medicarenhic.com/edi/download/mrepsoftware_1005.htm</a> .									
BENEFICIARY ELIGIBILITY ENROLLMENT									
<input type="checkbox"/> I am requesting access to use the Beneficiary Eligibility System. I understand that I am responsible for the Medicare beneficiary data I receive. If this data is mishandled in any way, I will be held responsible in accordance with Medicare requirements.									
OFFICE USE ONLY									
NEW SID		OLD SID		ADD TO EXISTING SID		SET UP IN TEST		SET UP IN PROD	

11/09/06

NHIC, Corp.	
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## MEDICARE PART B Electronic Data Interchange-Provider/Submitter Agreement

### SECTION 1 – BILLING AGREEMENT

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

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

Provider Name: \_\_\_\_\_

Physical Practice Address: (*Where services physically performed*)

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

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

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

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

I, \_\_\_\_\_, \_\_\_\_\_  
(PRINT NAME) (SIGNATURE)

authorize \_\_\_\_\_; Submitter ID: \_\_\_\_\_  
(SUBMITTER NAME)

to submit claims directly to NHIC, Corp. - Medicare B

electronically **effective** \* date: \_\_\_\_\_, and request the above provider number be

**disassociated from all previous Submitter ID's.**

*\* If the effective date is blank, this transaction will be effective the date document is received by EDI Support.*

### SECTION 2 – REMITTANCE AGREEMENT

To be completed **by Billing Service or Clearinghouse** to Receive an Electronic Remittance File on the 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.

\_\_\_\_\_  
(PRINT NAME) (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.

Please mail this form (facsimiles are only accepted if a current – original – EDI Agreement is on file) to the NHIC, Corp. office that processes your Medicare Part B claims:

**NHIC, Corp. - California**  
PO Box 2807  
Chico, CA 95927  
Attn: EDI Department  
FAX 530-879-2668

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

11/09/06