P.O. Box 7011 Northridge, Ca 91327-7011 * (818) 368-5501 * www.signatureclaims.net

Provider Sign-up Form Information

Florida Medicare

Completely fill in Section C.

If you want Electronic Remittance Advice, then fill in the section called "**FLORIDA ELECTRONIC DATA REQUEST (EDR) FORM**". You will receive your ERA from Signature Claims. NOTE: This often will END your paper EOBs.

Complete and mail this form to:

Florida Medicare EDI
PO Box 44071 – 14T
Jacksonville, FL 32231-4071

MEDICARE
Electronic Data Interchange

GENERAL COMPLETION INSTRUCTIONS FOR EDI ENROLLMENT FORM

Attention: The provider is required to notify Medicare EDI in writing in advance of any changes impacting their use of EDI and the effective date of such changes. Medicare EDI must be notified if the provider will begin, change, or discontinue using a billing service, clearinghouse, or other third party. The form necessary to notify us of such changes is the EMC Change of Information form that can be downloaded from our Web site at www.fcso.com. Select Medicare Electronic Services-Using EDI-Forms.

Section A-B: Each billing provider or supplier who is applying to exchange EDI transactions with Medicare should ensure they read and agree to the provisions in these sections of the document prior to signing the document. 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 Enrollment Form requirements remain in effect as long as that provider continues to use EDI transactions.

Section C: THIS SECTION MUST BE COMPLETED. IF ALL OF THE INFORMATION IS NOT COMPLETE, YOUR EDI FORM WILL BE RETURNED FOR THE ADDITIONAL INFORMATION.

PROVIDER NAME: Name of billing provider or supplier should be listed.

TITLE: Indicate the title of the billing provider or supplier listed in the Provider's Name section.

ADDRESS: Indicate the physical address where services are performed.

CITY/STATE/ZIP: Indicate the city/state/zip for the billing provider or supplier.

BY: The signature of the provider or authorized party for the provider is required. When the provider is using a third party, e.g., clearinghouse, billing service, etc., to exchange EDI transactions, the signature serves as the provider's authorization for the third party to act on behalf of the provider for the indicated EDI transaction(s). In such cases the provider is required to have on file, an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. **A representative from a billing service or clearinghouse is not authorized to sign on behalf of the provider.**

PRINTED NAME: The provider or authorized party for the provider printed name. **A representative from a billing service or clearinghouse is not authorized to sign on behalf of the provider.**

TITLE: Title of person completing enrollment form (e.g. Office Manager, MD, Billing Coordinator, etc.).

DATE: The date this document is signed by the provider.

Section D: ALL FIELDS ARE REQUIRED UNLESS OTHERWISE INDICATED AS OPTIONAL OR CONDITIONAL. IF ALL OF THE REQUIRED INFORMATION IS NOT PROVIDED, THE FORM WILL BE RETURNED FOR THE ADDITIONAL INFORMATION.

BILLING SERVICE/CLEARINGHOUSE (optional): If you are using a billing service or clearinghouse to submit your claims electronically, indicate the name of the company.

SENDER/SUBMITTER NUMBER (conditionally required): Indicate the sender/submitter number of the organization that will submit your electronic claims to Medicare. **If you use a clearinghouse or billing service for electronic claims submission, that sender/submitter number is required.** If you do not currently have a sender/submitter number and you are applying for a new sender/submitter number for direct billing, please leave this field blank. For direct billing, you must complete a New Installation Form and include it with the EDI Enrollment Form, if a signed EDI Enrollment Form has not previously been filed with our office.

CONTACT PERSON (optional): Name of the person to contact regarding this application.

TELEPHONE NUMBER (optional): Contact person's telephone number (with area code).

NPI: Please indicate the billing provider's National Provider Identifier (NPI) in the space provided. **The NPI is required on the EDI Enrollment Agreement for initial EDI Enrollment.** If you are a member of a group, indicate the group's NPI.

MEDICARE PROVIDER NUMBER: Please indicate the billing provider's Medicare provider number (if known). If you are a Medicare Part A provider (Florida only), please indicate your Medicare Part A billing provider number. If you are a Medicare Part B provider, please indicate your Medicare Part B billing provider number. If you are a member of a group, indicate the group's billing provider number.

TAX IDENTIFICATION OR SOCIAL SECURITY NUMBER: Please provide the billing provider's tax identification number. If you do not have a tax identification number, please provide the billing provider's Social Security Number.

EDI Enrollment Form

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 contractor 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, 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 Social Security Act (the Act);

14. That it will research and correct claim discrepancies;

15. That it will notify the carrier, MAC, FI, or other contractor if designated by CMS within 2 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' 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 designated by CMS sells directly, or indirectly, or by arrangement;

6. Notify the provider within 2 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.

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C. Signature:
I am authorized to sign this document on behalf of the indicated party and I have read and agreed to the foregoing provisions and acknowledge same by signing below.

____
Provider's Name

____
Title

____
Address

____
City/State/Zip

By______________________________ ______________________________
(signature) (printed name)

____
Title

____
Date

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D. PLEASE PROVIDE THE FOLLOWING MEDICARE INFORMATION

All Fields Are Required Unless Otherwise Indicated As Optional or Conditional

Sender/Submitter Number (Conditionally required if not applying for a new sender/submitter number) P7098

Contact Person (optional): Bill Greenland

Telephone Number (optional): (818) 368-5501

☒ **Billing Service/Clearinghouse Name (optional)**

SIGNATURE CLAIMS

Check below all that apply:

- ☐ **FL Medicare Part A provider's NPI** ______________
- ☐ **Medicare Part B provider's NPI (If you are a member of a group, indicate the group's NPI.)** ______________
- ☐ **Medicare Provider Number (if known)** ______________
- ☐ **Tax Identification or Social Security Number** ______________

Mailing Address:
Medicare EDI
PO Box 44071 – 14T
Jacksonville, FL 32231-4071

Telephone and Fax Numbers:
FL (904) 791-8767, option 2
CT (203) 639-3160, option 1
Fax (904) 791-6692

Physical Address:
Medicare EDI
532 Riverside Ave. 14T
Jacksonville, FL 32202-4918