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

# Provider Sign-up Form Information

## Kansas Medicare

Completely fill out both sets of forms.

You will need the Signature Claims information:

Signature Claims
PO Box 7011
Northridge, CA 91327-7011
phone- 818 368 5501
fax- 888 319 7457
Contact:Bill Greenland
Email: bi11@signatureclaims.net (That is Bee-eye-one-one)
WPS Submitter number: 11753

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**EDI ENROLLMENT FORM**

**This Agreement notifies Wisconsin Physician Services of the provider's consent to participate in Electronic Data Interchange (EDI). EDI may include claims and claims attachments, remittances, eligibility/benefits, claim status, and any other electronic information for Centers for Medicare and Medicaid Services (CMS) federal program data (including but not limited to Title XVIII of the Social Security Act (Medicare), and/or Section 1011 of the Medicare Modernization Act) covered under Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets or Section 1011 of the Medicare Modernization Act (MMA) legislation.**

**A. The provider agrees :**

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 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 signatures, or legally authorized signatures on behalf of beneficiaries, are on file;

4. That it will submit/request electronic transactions on only those beneficiaries with whom the provider has a professional relationship.

5. 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.

6. That the Secretary of Health and Human Services or his/her designee and/or the 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;

7. 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;

8. That it will submit claims that are accurate, complete, and truthful;

9. 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;

10. That it will affix the CMS-assigned unique identifier number (submitter *ID*) of the provider on each claim electronically transmitted to the A/B MAC, CEDI, or other contractor if designated by CMS;

11. 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;

12. 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;

13. 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;

14. That it will establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its 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 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);

15. That it will research and correct claim discrepancies;

16. That it will notify the 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.

17. That if it chooses to participate in electronic remittance transactions it will notify the CMS contractor of any changes in third-party services that it has authorized to access this information on their behalf via the EDI Enrollment form;

18. That if it chooses to use a Network Service vendor for eligibility verification transactions it will notify the CMS contractor of any changes in third-party service arrangements via the EDI Enrollment 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 A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the A/B MAC, CEDI or from any subsidiary of the A/B MAC, CEDI, other contractor if designated by CMS, or from any company for which the A/B MAC, CEDI has an interest. The A/B MAC, CEDI, 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 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 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.

**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.

EDI ENROLLMENT FORM

**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 WPS on my behalf.

Provider Name ______________________________________________________________

Provider Address ____________________________________________________________

City/State/Zip________________________________ __________ ________________

By ________________________________ ________________________________
Signature Printed name

Title____________________________________________ Date_________________________

Check all lines of business that apply:

Part A J5 [ ] Part B J5 [ ] Part A J8 [ ] Part B J8 [ ] J5 National Part A [ ]

**Type of Submission** (check all that apply)

Electronic Media Claims (EMC) ________ Direct Data Entry (DDE) ________

Group/Provider NPI Number___________________________ Group/Provider PTAN Number______________

WPS Submitter Number: _________________ ***(Required for batch billing only)***

Provider Contact Name __________________________________ Phone # _____________________________

Provider Email ___________________________________________ Fax # ______________________________

☐ By checking this box, you are authorizing a Third Party/Clearinghouse/Software vendor to send your Electronic Media Claims (EMC).

***** Please supply the complete name of the Third Party/Clearinghouse/Software vendor *****

Name: _________________________________Address:_________________________________________________

City: _________________________ State: _________ Zip: __________ Fax Number: __________________________

Contact:_____________________________________Contact Email address: ________________________________
(Printed Name)

Contact Phone Number: ________________________________ WPS Submitter Number:_____________________
(Please include extension #)

**Please mail or fax this completed form for Medicare Part A & B J5 MAC (IA, KS, MO, NE), Medicare Part A & B J8 MAC (IN & MI) or Medicare J5 National Part A to:**

**WPS Medicare EDI**
**1717 West Broadway**
**Madison, WI. 53713**
**Fax: (608) 223-3824**
**Phone (866) 503-9670**

# Electronic Remittance Advice (ERA) Authorization Agreement

This document is intended to establish Electronic Remittance Advice (ERA) enrollment. This document shall become effective when submitted by the provider. The responsibilities and obligations contained in this document will remain in effect as long as claims are submitted to WPS. 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.

## DEG1: Provider Information

Provider Name:

Doing Business As Name (DBA):

**Provider Address**

Street: City: State/Province:

Zip Code/Postal Code: Country Code:

## DEG2: Provider Identifiers Information

**Provider Identifiers**

Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN):

National Provider Identifier (NPI):

Other Identifier(s)

Assigning Authority: Trading Partner ID:

Provider License Number: License Issuer:

Provider Type: Provider Taxonomy Code:

## DEG3: Provider Contact Information

Provider Contact Name:

Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

## DEG4: Provider Agent Information

Provider Agent Name:

**Agent Address**

Street: City: State/Province:

Zip Code/Postal Code: Country Code:

Provider Agent Contact Name: Title:

Telephone Number: Telephone Number Extension:

Email Address: Fax Number:

## DEG5: Federal Agency Information

Federal Program Agency Name:

Federal Program Agency Identifier:

Federal Agency Location Code:

## DEG6: Retail Pharmacy Information

Pharmacy Name:

Chain Number:

Parent Organization ID:

Payment Center ID:

NCPDP Provider ID Number:

Medicaid Provider Number:

## DEG7: Electronic Remittance Advice Information

**Preference for Aggregation of Remittance Data**

Provider Tax Identification Number (TIN):

National Provider Identifier (NPI):

Method of Retrieval:

## DEG8: Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name:

Clearinghouse Contact Name:

Telephone Number: Email Address:

## DEG9: Electronic Remittance Advice Vendor Information

Vendor Name:

Vendor Contact Name:

Telephone Number: Email Address:

## DEG10: Submission Information

Reason for Submission: ◯ New Enrollment ◯ Change Enrollment ◯ Cancel Enrollment

**Authorized Signature**

Printed Name of Person Submitting Enrollment:

Submission Date: Requested ERA Effective Date:

In order to determine the status of this enrollment, please contact the EDI department by phone or email using the following information:

**WPS Health Insurance**
**ARISE Health Plan**
**EPIC**

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 West Broadway
Madison, WI 53713

Fax: (608) 223-3824
Phone: (800) 782-2680
Email: edi@wpsic.com

**Tricare for Life,**
**Tricare Overseas**

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 West Broadway
Madison, WI 53713

Fax: (608) 223-3824
Phone: (800) 782-2680
Email: edi@wpsic.com

**Veterans Administration – VA**
**VAPCCC Region 3, VAPCCC Region 5A, VAPCCC Region 5B and VAPCCC Region 6**

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 West Broadway
Madison, WI 53713

Fax: (608) 223-3824
Phone: (800) 782-2680
Email: edi@wpsic.com

**MEDICARE**
**MACJ5 National Part A, MACJ5 Part A/B, MACJ8 Part A/B**

WPS Medicare EDI
1717 West Broadway
Madison, WI 53713

Fax: (608) 223-3824
Phone: (866) 503-9670
Email Medicare part A:
edimedicarea@wpsic.com

Email Medicare part B:
edimedicareb@wpsic.com

For further updates visit our website at: http://www.wpsic.com/edi/tools.shtml