



Line of Business Information: _____

Action Requested: _____

Submitter ID (if available): _____ Date: _____

Receiver ID: _____

Submitter Name: _____

Type of Submitter: _____

EDI Contact Person: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ ZIP: _____

Submitter Email Address: _____

Note: Email will be the primary method of communication.

Report Response Format: _____

Data Compression: _____

Name of Software Vendor: _____ Vendor Security ID: _____

Name of Network Service Vendor: _____

Providers Information (If this is a group practice, enter the group name, group PTAN and group NPI on all forms)

Provider Name: _____

Provider Address: _____

Provider City: _____ State: _____ ZIP: _____

Provider Email: _____ Provider Phone #: _____

Provider # - PTAN: _____ NPI: _____ Tax ID: _____

Action Requested: Submit Claims Receive Electronic Remittances Direct Data Entry (DDE) RCD Submissions

Provider Authorization

I hereby authorize the above submitter to receive the items notated above on my behalf. I understand that these items contain payment information concerning my processed Medicare claims. I am authorized to endorse this access on behalf of my company, and I acknowledge that is my responsibility to notify Palmetto GBA EDI in writing if I wish to revoke this authorization.

Name: _____

Title: _____

Signature: _____ Date: _____

Medicare Electronic Data Interchange Enrollment Agreement

Enrollment Agreement Instructions

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

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 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 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 6 years, 3 months after the bill is paid;
9. 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;
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 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)).
14. That it will research and correct claim discrepancies.

15. 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

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

1. Transmit to the provider an acknowledgment of claim receipt;
2. Affix the 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 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 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 Palmetto GBA on my behalf.

Provider's Name: _____

Address: _____

City/State/ZIP: _____

Authorized Signature: _____ Date: _____

By (Print Name): _____ Title: _____

Email: _____

Medicare Provider Number (PTAN): _____

National Provider Identifier (NPI): _____

Part A/Part B/HHH EDI Application Form Instructions

[Back to Form](#)

The purpose of the **Part A/Part B/HHH EDI Application Form** is to enroll providers, software vendors, clearinghouses and billing services as electronic submitters and recipients of electronic claims data. **It is important that instructions are followed and that all required information is completed. Incomplete forms will be returned to the applicant, thus delaying processing.**

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 completing the form properly.

| Form Field Name | Instructions for Field Completion |
|-------------------------------------|--|
| Line of Business Information | Please choose from the drop-down list the line of business and state for which you will be transmitting. |
| Action Requested | Choose from the drop-down list the action to be taken on the application form. <ul style="list-style-type: none"> • Add Provider to an existing Submitter - select if you need to add additional providers to an existing Submitter ID. The Submitter ID is required. • Add Provider to an existing Receiver – select if you need to add a provider to an existing Receiver ID. The Receiver ID is required. • Add Provider to an existing Submitter ID and Receiver ID – select if you need to add a provider to an existing Submitter ID and Receiver ID. The Submitter ID and Receiver ID are required. This option is only valid for North Carolina Part A and Virginia Part B only. • Change/Update Submitter Infor – select if you request to change or update information about the Submitter and/or Receiver. Be sure to include your current Submitter ID and/or Receiver ID. • Delete – select if you request to delete a provider. Be sure to include your submitter ID. • Apply for New Submitter ID – select if you are a new direct submitter. • Apply for New Receiver ID – select if you would like to request a Receiver ID to download electronic remittances. This option is available for North Carolina Part A and Virginia Part B only. • Apply for New Submitter ID and Receiver ID – select if you would like to request a Submitter ID and Receiver ID. This option is available for North Carolina Part A and Virginia Part B only. • DDE Only – Select if you are requesting DDE access only. |
| Submitter ID | The Submitter ID is used by the submitter to communicate with Palmetto GBA electronically. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID if requested. For changes or updates, enter the Submitter ID to which the change/updates should be applied. |
| Date | Please enter the date the application is completed. |
| Receiver ID | This option is available for North Carolina Part A and Virginia Part B only. The Receiver ID is used by the remittance receiver to download remittance advices/notices via Palmetto GBA electronically. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID if requested. For changes or updates, enter the Receiver ID to which the change/update should be applied. |
| Submitter Name | Enter the name of the entity (provider, software vendor, billing service or clearinghouse) that will actually be communicating electronically with Palmetto GBA. |
| Type of Submitter | Select from the drop-down list whether you are a Provider, Billing Service, Clearinghouse or Software Vendor. |
| EDI Contact Person | The name of the submitter's primary EDI contact. This is the person Palmetto GBA will contact if there are questions regarding the application or future questions about their communications. |
| Phone | The area code and phone number of the Contact Person listed. |
| Fax | The fax number for this submitter. |
| Address | The mailing address of the submitter. |
| City, State, ZIP | The city, state and ZIP code of the submitter. |
| Submitter Email Address | The email address of the contact person listed. Note: This will be the primary method of communication. The email address will also receive EDI Tracking Numbers used to monitor the processing status of your EDI forms. |

EDI Application Form Instructions

This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

| Form Field Name | | Instructions for Field Completion | |
|--|--|-----------------------------------|--|
| Report Response Format | Select from the drop-down list the format in which you will receive GpNet Claims Acceptance Responses. | | |
| Data Compression | To receive files compressed for faster transmission, select from the drop-down list which data compression utility you support. | | |
| Name of Software Vendor | Indicate the name of the software vendor you are using, if applicable. | | |
| Vendor Security ID | Include Vendor Security ID number if known. | | |
| Name of Network Service Vendor | Indicate the name of the network service vendor you are using, if applicable. | | |
| Providers Information If this is a group practice, enter the group name, group PTAN and group NPI on all forms. | | | |
| Provider Name | List the provider whose bills will be submitted by the submitter named above. This name must match the name submitted on the CMS 855 Medicare Enrollment Application. If this is a group practice, please enter the group name, group PTAN and group NPI on all forms. | | |
| Provider Email | Indicate the email address for the provider listed above. This email address will be the primary source of communications regarding approval of changes to their EDI options. | | |
| Provider Address | The mailing address of the provider. | | |
| City, State, ZIP | The city, state and ZIP code of the Provider. | | |
| Provider # – PTAN | Indicate the Medicare Provider Number (PTAN). | | |
| NPI | Include the National Provider Identifier (NPI). | | |
| Tax ID | Enter the Tax Identification Number for the provider. | | |
| Action Requested: | Check all boxes that apply. <ul style="list-style-type: none"> • Submit Claims – Check if the application is for the submitter to submit claims electronically for this provider. • Receive Electronic Remittances – Check if the submitter wants to receive Electronic Remittances for the provider indicated. Provider must be submitting claims electronically to receive Electronic Remittances. • Direct Data Entry (DDE) – Check if the submitter currently uses or plans to use the Direct Data Entry (DDE). Note: The DDE Enrollment Form must be submitted if this option is selected (Part A only). • RCD Submissions – Select if submitting claims for the Review Choice Demonstration (RCD). | | |
| Provider Authorization This section must be completed by a provider to authorize a clearinghouse and/or billing service as their electronic submitter and recipient of electronic claims data. | | | |
| Name | The name of the person Palmetto GBA will contact if there are questions regarding this Authorization Form. | | |
| Title | The title of the person Palmetto GBA will contact if there are questions regarding this Authorization Form. | | |
| Signature | The signature of the listed provider's authorized contact. | | |
| Date | Please enter the date the application is completed. | | |

Once you have completed the application form, please retain a copy for your records and fax **or** email the original via the appropriate fax number or email address below. Your Submitter ID and software (if applicable) will be processed within 15 business days of receipt of completed forms.

Completed forms must be faxed **or** emailed to:

| | | | |
|---|--|---|--|
| Jurisdiction J Part A (AL, GA, TN) | | Jurisdiction J Part B (AL, GA, TN) | |
| 803-870-0163 EDIENROLL.PARTA@PalmettoGBA.com | | 803-870-0164 EDIENROLL.PARTB@PalmettoGBA.com | |
| Jurisdiction M Part A (SC, NC) & HHH | | Jurisdiction M Part B (SC, NC, VA, WV) | |
| 803-699-2429 EDIPartA.ENROLL@PalmettoGBA.com | | 803-699-2430 EDIPartB.ENROLL@PalmettoGBA.com | |

[Back to Form](#)

EDI Application Form Instructions

This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

Part A/Part B/HHH EDI Enrollment (Agreement) Form Instructions

[Back to Form](#)

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

Providers are obligated to notify Medicare by letter of:

- Any changes in their billing agent or clearinghouse.
- The effective date of which the provider will discontinue using a specific billing agent or clearinghouse.
- If the provider wants to begin to use additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouse begins to use alternate software, the clearinghouse is 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.

General Instructions

- Please ensure that you include your **Medicare Provider Number (PTAN)** and **National Provider Identifier (NPI)** where requested on the EDI Enrollment Form.
- If the submitter will be submitting for multiple providers, this form must be completed by **each** provider whose claim data will be submitted.
- If a provider is a member of a group, only one agreement per group is required.
- The entire form must be read carefully, dated with day, month and year.
- The name of the provider must be printed in the space provided, an authorized officer's name (printed), authorized officer's title and signature.
- When completed, the properly executed **2-page EDI Enrollment Form** must be returned **with** the **EDI Application** form.
- Fax **or** email completed forms to:

| Jurisdiction J Part A (AL, GA, TN) | Jurisdiction J Part B (AL, GA, TN) |
|---|---|
| 803-870-0163 EDIENROLL.PARTA@PalmettoGBA.com | 803-870-0164 EDIENROLL.PARTB@PalmettoGBA.com |
| Jurisdiction M Part A (SC, NC) & HHH | Jurisdiction M Part B (SC, NC, VA, WV) |
| 803-699-2429 EDIPartA.ENROLL@PalmettoGBA.com | 803-699-2430 EDIPartB.ENROLL@PalmettoGBA.com |

Note: If the submitter will be an entity other than the provider, the submitter must complete the EDI Application form and the provider must sign the EDI Application and complete the EDI Enrollment Form. The EDI Application form must be returned with the EDI Enrollment Agreement Form for each provider unless requesting eServices access only.

IMPORTANT NOTE

The provider address shown on the EDI Enrollment Form must match the address that was submitted to our Provider Enrollment Department when enrolling for a provider number. If the address on the completed EDI Enrollment Form does not match, your EDI Enrollment Form will be rejected.

[Back to Form](#)