

Payer Agreement Instructions for Georgia Medicaid - 00006

Important Notes

The provider **must** be enrolled with the payer and have a valid Provider Identification Number (PIN) before completing the agreement to submit electronic claims. Please wait until the PIN has been assigned **before** completing these forms requesting submission of electronic claims. Please do not list the PIN as "pending".

To obtain a PIN for a specific payer, **the provider or Billing Service** must contact the payer's Provider Relations Department. NDCHealth **cannot** make this request for the provider.

- If making copies include *all* pages of this agreement and be sure they are all legible.
- Submit one agreement for each Provider ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 4- 6 weeks. If you receive an approval letter from the payer, contact us via phone or fax a copy to us. DO NOT transmit your claims until you receive an approval letter from ProxyMed or your claims will reject.

Guidelines for completing: Georgia Medicaid - Payer ID 00006

Power of Attorney For Electronic Claims

Field	Instructions
<i>Provider's Name</i>	Complete as indicated.
<i>Name of Billing Service</i> <i>Billing Service Trading Partner ID</i>	ProxyMed, Inc. 54829
<i>Printed Name of Enrolled Provider, Signature of Provider or Authorized Representative, Title of Authorized Representative:</i>	<i>Original</i> signature of the provider or authorized representative is required. Stamped signatures are not acceptable.

The Power of Attorney must be notarized.

Return the Power of Attorney to the Payer:

Physical address for USPS, FedEx, UPS, etc.

ACS EDI Gateway, Inc.
Attn: EDI Enrollment Unit
PO Box 4000
McRae, GA 31055

POWER OF ATTORNEY FOR ELECTRONIC CLAIMS SUBMISSION

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, _____ (*Provider's Name*), with Provider Number(s) _____ hereby appoints _____

(*Name of Billing Service*), _____ (*Billing Service Trading Partner ID*) as attorney-in-fact for the benefit of Provider, and in Provider's name, place and stead for the following purposes:

To act as billing service for Provider in submitting Provider's medical assistance claims by Computer Media Input to the Department of Community Health, Division of Medical Assistance (the "Department"), for reimbursement of Provider under the Title XIX ("Medicaid") program in Georgia;

To act as Provider's authorized agent for purposes of signing, on behalf of Provider, the certification statement herein in connection with each Computer Media Input submission of medical assistance claims:

"I hereby certify that all information contained on and submitted by Computer Media Input is true, accurate, and complete, and that to the best of my knowledge, information and belief, the services for which medical assistance was sought, in fact, have been rendered by Provider as claimed. Furthermore, I understand and acknowledge that the Department will rely on this certification in the payment of medical assistance, which payment will be made from State and Federal funds, and that the submission of any false claims, information, or documents or the concealment of any material facts is a crime under Federal and State laws."

To maintain all original source documents for six (6) years following the month of payment, and to ensure that every electronic entry can be associated and identified with a source document.

Provider agrees that the billing service is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable.

Provider understands that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of Provider for the truthfulness, completeness and accuracy of any and all medical assistance claims submitted by the appointed billing service, and in no way forecloses the application of penalties that may be assessed under the False Claims Act and other applicable federal and state laws.

IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.

This _____ day of _____, in the year _____.

Printed Name of Enrolled Provider

By: _____
Signature of Provider or Authorized Representative

Title of Authorized Representative

Sworn to and subscribed before me
this _____ day of _____, in the year _____.

(Notary Public)

My Commission expires: _____

