

**Kentucky Medicare (MR052) and Indiana Medicare (MR041)
Payer Agreement Instructions**

Are you set up with your Payer?

This enrollment form is for submitters who have completed all necessary arrangements with this payer. Although payer requirements vary, please be sure to:

- Register your NPI with this Payer
- Contract with this Payer, if needed

In addition there may be other EDI payer requirements. For more payer specific information please contact the Payer's Provider Relations department.

PerSe's Enrollment Forms

- Please complete a McKesson Exhibit B and Carrier Approval Tracking Form (CAT) for each Tax ID and fax it to McKesson at 480-635-8271.
- This form can be used if you are enrolling with one or more new Payer(s) or if you are enrolling a new rendering provider with your existing Payer(s).
- Go to: <http://www.medisoft.com/TransactionSolutions/documentation.asp>
or <http://www.medisoft.com/TransactionSolutions/documentation.asp>

Payer Enrollment Form

- Some Payers require original forms.
- If the payer accepts copies, be sure to include all pages of this agreement and verify they are legible.
- Submit one agreement for each Group ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 3 - 4 weeks.

Payer Approval

- In some cases a payer will send you an approval letter but they will not notify us. If you receive payer approval you must let us know. You can call, fax or email a copy of the approval letter to McKesson Enrollment. Our contact information is listed above.
- **DO NOT** transmit your claims until you receive an approval notice from McKesson or your claims will reject.

**Guidelines for completing: Kentucky Medicare - Payer ID MR052 and
Indiana Medicare - Payer ID MR041**

When you have completed this Agreement please send or fax to the Payer:

Fax

(502) 423-2356

Mailing Address

National Government Services
Attention: EDI Unit
P. O. Box 3449
Louisville, KY 40232-44900

Physical Address for FedEx, UPS, etc.

National Government Services
Attention: EDI Unit
9901 Linn Station Road
Louisville, KY 40223

Electronic Data Interchange (EDI) Enrollment Form- Section C

Field	Instructions
<i>Provider / Supplier / Facility Name, Address, City / State / Zip, Telephone, email</i>	Provide requested information
<i>Authorized Signature</i>	Agreement must be signed with the <u>original</u> signature of the provider or authorized representative. Stamped signatures will not be accepted.
<i>Medicare Provider / Supplier / Facility Number</i>	Medicare ID assigned to the practice / provider. If are a Group with a Group ID, enter that ID in this field.
<i>NPI</i>	Self Explanatory

Please complete and return to:

Mail to: National Government Services
Attn: EDI Unit
P.O. Box 34490
Louisville, KY 40232-4490

Overnight Mail: National Government Services
Attn: EDI Unit
9901 Linn Station Road
Louisville, KY 40223

Fax to: (502) 423-2356

ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to 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 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:
 - o Beneficiary's name
 - o Date(s) of service
 - o Beneficiary's health insurance claim number
 - o Diagnosis/nature of illness
 - o 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 6 years, 3 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 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 the Act).
14. That it will research and correct claim discrepancies.

15. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare and Medicaid Services Agrees To:

1. Transmit to the provider an acknowledgment 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 (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 / Supplier / Facility Name	Telephone Number
Address	Authorized Signature of Provider / Supplier / Facility
City / State / Zip	Medicare Provider / Supplier / Facility Number
E-Mail Address	National Provider Identifier (NPI)

Providers are bound by the requirements as noted in the EDI Enrollment form. These requirements will remain in effect as long as the provider continues to use EDI Transactions. The original authorized signature is valid regardless of internal employment changes within the Provider's operations.

To submit a form for multiple providers, please complete the EDI Enrollment Agreement Addendum.

Submitter Information (Leave blank if you are currently applying for a new electronic Submitter ID.)

Sender ID #: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

NOTE: An incomplete form will be returned

