



Enrollment Department  
 MedAvant  
 1854 Shackelford Court,  
 Suite 200  
 Norcross, GA. 30093-2954

**Phone:** (800) 792-5256 Option 1  
**Fax:** (404) 877-3324  
 provider.enrollment@MedAvanthealth.com

**Payer Agreement Instructions for Medicare for:  
 Maine, Massachusetts, New Hampshire, Vermont**

*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. MedAvant **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 Group ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 3-4 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 MedAvant or your claims will reject.

*Guidelines for completing:*

*Maine Medicare - Payer ID MR043*

*Massachusetts Medicare - Payer ID MR061*

*New Hampshire Medicare - Payer ID MR051*

*Vermont Medicare - Payer ID MR062*

**EDI Profile Form**

Field	Instructions
<b>Provider Office Practice Information Section</b> <i>Date, Name, Address, City, State, Zip, Contact (Full Name), Phone, Fax:</i>	Complete as indicated.
<i>Medicare B Provider #:</i>	The Group ID or Provider ID assigned to the Practice/ Provider by NHIC Medicare.
<b>Submitter Information</b>	Pre-filled by MedAvant.
<b>Software Information</b> <i>Company Name, Address, City, State, Zip, Contact (Full Name), Phone, Name of Software:</i>	Complete as indicated.
<b>If you want to receive electronic remittance.....</b>	NA



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**Electronic Data Interchange (EDI) Enrollment Form**

Field	Instructions
<i>Provider's Name, Title, Address, City/State/Zip:</i>	Complete as indicated.
<i>Signature:</i>	Name of Authorized Representative at Practice/ Provider. This agreement must be signed with the <b>original</b> signature of the provider or authorized agent. Stamped signatures will not be accepted.
<i>Title:</i>	Title of person signing on behalf of the Practice/Provider.
<i>Date:</i>	Date signed.
<i>Submitter Name/Billing Agent:</i>	Pre-filled by MedAvant.
<i>Submitter ID:</i>	Pre-filled by MedAvant.
<i>Provider Number:</i>	Provider/Group ID Number assigned by NHIC Medicare.
<i>Software Vendor:</i>	Software Vendor Information not Required.
<i>Vendor Phone Number</i>	Pre-filled by MedAvant.

**Medicare Part B Electronic Data Interchange-Provider/ Submitter Agreement**

Field	Instructions
<i>Date, Provider #:</i>	Enter date, Group ID or Provider ID assigned to the Practice/ Provider by NHIC Medicare.
<i>Provider Name, Physical Practice Address, City/State/Zip, Contact Name, Phone Number:</i>	Complete as indicated.
<i>I, (print name), (signature) authorize.....</i>	Name of Authorized Representative at Practice/ Provider. This agreement must be signed with the <b>original</b> signature of the provider or authorized agent. Stamped signatures will not be accepted.
<i>Submitter Name, Submitter ID:</i>	Pre-filled by MedAvant.
<i>Effective Date:</i>	<b>Important field.</b> If you are currently submitting through another Trading Partner, we suggest you list an effective date for submitting claims through MedAvant. This will provide a transition time until MedAvant is successfully processing your claims. If an effective date is not included, then NHIC will "detach" your Group/ Provider ID from your current Submitter ID the day they process the new agreement. This means that they will no longer accept claims from your current submitter ID.
<i>Complete if you will receive an electronic remittance file....</i>	NA



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**Return the Agreement to the Payer:**

**Physical address for FedEx, UPS, etc.**

NHIC – New England  
Attention: EDI Department  
PO Box 9104  
Hingham, MA 02044

**MedAvant's Claims Enrollment Form**

Please complete a MedAvant Claims Enrollment Form for each Tax ID and fax it to MedAvant at: (404) 877-3324. 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).

**The Claims Enrollment Form, with instructions  
is located at:**

<http://www.MedAvanthealth.com/payerlist/default.asp>

**Questions? Contact MedAvant enrollment at:  
(800) 792-5256 Option 1**

NHIC, Corp	
Document Name: EDI Profile Form	Doc. Number: FRM-EDI-0004
Release Date: 08/21/2008	Version: 23.0

## EDI PROFILE FORM

**Required, complete this form, MAIL it with Signature Page, to receive electronic remittance\* include number 2 or 3**

- 1) EDI Enrollment Form Signature Page (required for new enrollments; original signature of Owner, President or CEO required)
- 2) Electronic Remittance Advice (ERA) Enrollment Form (ERA to you when submitting your claims directly to NHIC, Corp.)
- 3) or, Provider/Submitter Agreement (ERA to the billing agency/clearing house submitting Medicare claims on your behalf)

**Mail all applicable forms to the NHIC, Corp. office that processes your Medicare Part B claims:**

NHIC, Corp.- New England  
 Attn: EDI Department  
 PO Box 9104  
 Hingham, MA 02044-9104

PROVIDER OFFICE PRACTICE INFORMATION (Physical location where you PERFORM services)									
PIN/PTAN #:				NPI #:					
NAME:							DATE:		
ADDRESS:					EMAIL:				
CITY:					STATE:		ZIP:		
CONTACT (FULL NAME):					PHONE:				
CONTACT (FULL NAME):					FAX #:				
SUBMITTER INFORMATION (Who will submit claims)									
PLEASE CHECK THE APPROPRIATE BOX				PROVIDER: <input type="checkbox"/>		BILLING AGENT: <input type="checkbox"/>		CLEARING HOUSE: <input type="checkbox"/>	
NAME:					SID# (Submitter ID#):				
ADDRESS:				EMAIL ADDRESS:					
CITY:				STATE:			ZIP:		
CONTACT (FULL NAME):					PHONE:				
CONTACT (FULL NAME):					FAX #:				
SOFTWARE INFORMATION (The type of software/operating system)									
COMPANY:									
CONTACT (FULL NAME):					PHONE:				
NAME OF SOFTWARE:					OPERATING SYSTEM:				
ELECTRONIC REMITTANCE ADVICE (ERA) (Electronic version of paper explanation of benefits (EOMB / SPR))									
<p>*An Electronic Remittance Advice (ERA) file can allow you to automatically post to the accounts receivable module if your practice management software allows for that capability. If your software is capable and you wish ERA, choose the <u>ERA file format</u> check box below.  <b>NOTE:</b> If a billing agency or clearinghouse will receive remittance on your behalf, the "Provider/Submitter Agreement" MUST be submitted with this form and it MUST be signed by the provider AND the billing agency/clearinghouse representative, in order to add ERA.  <b>For paper remittance, skip this section.</b></p>									
YES, SEND COMPRESSED ERA FILES (ZIPPED) <input type="checkbox"/>					YES, SEND UNCOMPRESSED ERA FILES (UNZIPPED) <input type="checkbox"/>				
Take advantage of the <b>FREE Medicare Remit Easy Print (MREP)</b> software now available for viewing and printing the HIPAA compliant ERA! Download the MREP software available at <a href="http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp">http://www.cms.hhs.gov/AccessstoDataApplication/02_MedicareRemitEasyPrint.asp</a> .									
BENEFICIARY ELIGIBILITY ENROLLMENT									
I am requesting access to use the Beneficiary Eligibility System. I understand that I am responsible for the Medicare beneficiary data I receive. If this data is mishandled in any way, I will be held responsible in accordance with Medicare requirements. NOTE: only non-HIPPA files are supported.									
OFFICE USE ONLY									
NEW SID		OLD SID		ADD TO EXISTING SID		SET UP IN TEST		SET UP IN PROD	

**MEDICARE – NHIC, CORP.**  
**ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM**

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or 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 signature, 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 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 six years, three 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 (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 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 Social Security Act (the Act));

14. That it will research and correct claim discrepancies;
15. That it will notify the CMS contractor within 2 business days if any transmitted data are received in an unintelligible or garbled form.

**B. The Centers for Medicare & Medicaid Services will:**

1. Transmit to the provider an acknowledgement 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 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 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. (*\*Original signature required, PLEASE USE BLUE INK*)

Provider/Supplier Business Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Signature (Authorized Rep)\* \_\_\_\_\_

Printed Name (Authorized Rep) \_\_\_\_\_

Title \_\_\_\_\_

Date \_\_\_\_\_

Submitter Name/Billing Agent \_\_\_\_\_

Software Vendor \_\_\_\_\_

Submitter ID \_\_\_\_\_

Vendor Phone Number \_\_\_\_\_

PIN/PTAN Number \_\_\_\_\_

NPI Number \_\_\_\_\_

NHIC, Corp.	
Document Name: Electronic Data Interchange-Provider/Submitter Agreement	Doc. Number: FRM-EDI-0005
Release Date: 08/21/2008	Version: 23.0

## MEDICARE PART B Electronic Data Interchange-Provider/Submitter Agreement

### SECTION 1 – BILLING AGREEMENT CHANGE REQUEST

To be completed by **Medicare Part B Provider** if an entity is submitting claims on behalf of the provider.

Date: _____ NPI #: _____ *PIN/PTAN #: _____	
Provider Name: _____	
Physical Practice Address: ( <i>Where services physically performed</i> )	
Street Address: _____	
City/State/Zip: _____	
Contact Name: _____	
Phone Number: _____	
I, _____, + _____	Title: _____
(PRINT NAME)	(SIGNATURE)+
Authorize; _____	Submitter ID: _____
(SUBMITTER NAME)	
to submit claims directly to NHIC, Corp. - Medicare B electronically, and request the above provider number be <b>**removed from Submitter ID(s):</b> _____.	
<p><b>+ Authorization signature must be from the President, CEO or Owner only.</b>  **A PIN/PTAN # (*provider number) may only be linked to one submitter number. Therefore, this form will not be processed if your provider number is linked to more than one submitter number and you do not indicate what submitter number(s) to remove.</p>	

**This form is only accepted if a current – original – EDI Enrollment Form is on file with the NHIC Corp office that processes your Medicare Part B claims.**

### SECTION 2 – REMITTANCE AGREEMENT

To be signed by **Billing Service or Clearinghouse** only if you request to receive an Electronic Remittance File on behalf of a Medicare Part B Provider.

A billing service or clearinghouse may accept remittance files on behalf of a provider(s), but the billing service or clearinghouse is <b>PROHIBITED</b> from viewing, storing, modifying or reporting the data for its own use.	
_____	Title: _____
(PRINT NAME)	(SIGNATURE)
The signature on this form signifies your agreement with this requirement. This document must be signed by a representative from the Billing Service or Clearinghouse.	
All Medicare beneficiary specific information is confidential and subject to the requirements of 1106(a) of the Social Security Act.	

**NHIC, Corp. - New England**  
PO Box 9104  
Hingham, MA 02044  
Attn: EDI Department  
FAX 781-741-3523

