

Montana Medicare – Payer ID MR047 Payer Agreement Instructions

Are you set up with the 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. You must have a valid Provider Identification Number (PIN).

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

McKesson Requirements

Complete the Exhibit B & Carrier Agreement Tracking Form (CAT Form) and fax to the McKesson EDI Enrollment Department at: 800-633-4763. These forms are included in the next two pages.

- This form is used to update the provider/practice profile with the correct information so that approval can be obtained from the payer for electronic submission.
- This form can also be used if you are making changes to an existing setup for this payer, i.e. change to Provider PIN or NPI.
- Please ensure that any tracking information is included. This is used when contacting the payer for approvals.
- Failure to complete this form and submit to McKesson may delay the processing of this payer with the clearinghouse.
- The Exhibit B & CAT Form does not go to the payer, only to McKesson EDI Enrollment.

Payer Enrollment

- Some payers require original forms.
- If the payer accepts copies, be sure to include all pages of the agreement and verify that they are legible.
- Submit one agreement per Provider Group ID
- Incomplete or incorrect agreements may be denied or returned by the payer and may require the enrollment process be started from the beginning.
- Approvals can take 3 – 4 weeks.

Payer Approvals

- In some cases the payer will send the approval to the provider/practice instead of notifying the clearinghouse. If you receive payer approval please let us know by faxing a copy to EDI Enrollment at: 800-633-4763.
- DO NOT transmit claims to this payer until you have verified with the Enrollment Department that the clearinghouse has received and updated the approval in their system.

Guidelines for completing: Montana Medicare- Payer ID MR047

When you have completed this agreement please fax to the payer at:

Fax:

(406) 447-3501

Electronic Data Interchange (EDI) Enrollment Form – Section C

Section	Instructions
Provider Name/Address:	Self Explanatory
By, Title & Date:	The signature and title of the Provider or the person authorized to sign on behalf of the provider and that persons title and date

Once the Medicare form(s) has been completed and faxed to the payer, please complete the **McKesson Ex. B & CAT Form** and fax to:

McKesson EDI Enrollment

800-633-4763

FAX TO 1-800-633-4763

Each provider in the practice planning to submit health care transactions electronically must be included in this enrollment form. If a provider has more than one office, please complete a separate form for each office.

PLEASE CHECK ONE OF THE BELOW CHOICES

- Add on Provider (Adding Provider to existing McKesson Account)*
- Add on Payer (Adding Payer to a Provider with an existing McKesson account)**
- Update or Change to a Provider's PIN or Group Number for requested payers.**

*Adding a provider to an account may result in a pricing increase depending on the pricing plan you are currently on. If you are not sure what pricing plan you are on, please contact your Value Added Reseller or the EDI Enrollment Department at 1-800-689-4550

** If adding or changing information regarding an Insurance Carrier/Payer for an existing provider you must also complete the Carrier Agreement Tracking Form (CAT Form) which is page 2 of this document.

Client ID: _____ Practice Tax-ID: _____

Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ VAR # _____

Telephone: _____ Facsimile: _____

Billing service name: _____
ID: _____

Billing Service Tax

(If applicable)
applicable)

(If

<i>First Name</i>	<i>Last Name</i>	<i>Credential</i>	<i>Specialty</i>	<i>Individual NPI</i>	<i>Group NPI</i>

Practice Name:	
Practice Tax ID:	

Please include this form with the Exhibit B. Complete this form for each provider in the practice after all agreements have been forwarded to the respective carriers. You may wish to retain a copy of this form for your records.

In the grid below, please enter **ALL** of the requested information for each carrier/payer to enroll. **This is critical information that is required to complete your enrollment process. The clearinghouse cannot contact payers to confirm your approval for electronic transmission without first knowing the date agreements were mailed to them.**

***Please indicate the appropriate Payer ID Number below each payer as indicated in the payer directory. The Phoenix Payer Directory can be found online at http://www.lytec.com/download/Phoenix_Payer_List.pdf for Lytec users or at http://www.medisoft.com/download/Phoenix_Payer_List.pdf for Medisoft users**

Payer	Provider #1	Provider #2	Provider #3
	Name:	Name:	Name:
	Ind NPI:	Ind NPI:	Ind NPI:
	Group NPI:	Group NPI:	Group NPI:
Medicare	Ind #	Ind #	Ind #
	Grp #	Grp #	Grp #
Medicaid	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
BCBS	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
TriCare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
RR Medicare	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
Other	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #

Please note the date on which you sent each carrier agreement to the carrier and the service used to send it (i.e., UPS, FedEx, Airborne Express, etc.) as well as a package tracking number, if applicable.

Carrier/Payer Name	Date Mailed	Service Used	Tracking Number

Electronic Data Interchange (EDI) Enrollment Form

The provider agrees to the following provisions for submitting Medicare claims electronically to Centers for Medicare & Medicaid Services (CMS) or to CMS's 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:

- * 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 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 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's 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's Name/address:

Name:

By:

Title

Date

Licensors: Blue Cross Blue Shield of Montana
560 N. Park Ave.
Helena, MT 59601



By

Robert J. Janicek, Director, Blue Cross Blue Shield of Montana
Printed Name

Date _____