

Payer Agreement Instructions for North Carolina Medicare -MR020

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. Per-Se **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 Tax ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.

Guidelines for completing: North Carolina Medicare- Payer ID MR020

Part B EDI Customer Profile Form

Field	Instructions
<i>Sections 1 (Options)</i>	Pre-Filled by MedAvant
<i>Section 2 (Customer Information)</i>	Required. Please Complete
<i>Sections 3, 4, 5 and 6</i>	These sections are pre-filled. No entry required.
<i>Section 7</i>	Please Read
<i>Section 8</i>	Briefly describe changes you are requesting
<i>Section 9 (Provider Signature & Date)</i>	This agreement must be signed with the <u>original</u> signature of the physician. If this is a group, only one physician needs to sign. Stamped signatures will not be accepted.

EDI Enrollment Form- Section C

Field	Instructions
<i>Complete all fields</i>	
<i>By (indicates signature)</i>	This agreement must be signed with the <u>original</u> signature of the physician. If this is a group, only one physician needs to sign. Stamped signatures will not be accepted.



Instructions for Part B EDI Forms

IMPORTANT: Read this before completing your application. Incomplete or incorrect applications will be returned.

The entity performing the billing must complete this form.

New Submitter – Enrolling

To enroll in electronic billing, you must complete and sign both the Part B EDI Customer Profile and EDI Enrollment Form.

Part B EDI Customer Profile Form

Sections 1, 2, 3, 4, and 9: Required.

Section 4: Use to note your third party information. Please complete this section in its entirety.

Section 5: Used to note the electronic features the provider has elected to use. If unsure, contact your vendor for the format and version.

Section 6: Used to authorize CIGNA Government Services to release patient and/or provider information to a provider’s billing service or clearinghouse.

Section 8: Used to describe changes that you are requesting.

Section 9: The provider must sign the form. Mail or fax signed forms to the office listed on the form.

EDI Enrollment Form

Read the entire form carefully to understand your agreement with Centers for Medicare and Medicaid Services and complete section C including signature of provider. All of the pages must be returned to CIGNA Government Services.

Existing Submitter – Making a Change or Addition

Part B EDI Customer Profile Form

Existing submitters may change or add information to their profile using the Part B EDI Customer Profile form.

<i>If you want to:</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>8</i>	<i>9</i>
Change address, phone, or contact information	X	X					X	X
Change transmission information	X	X	X	X		X*	X	X
Add electronic features (ERN, ERL, Beneficiary Eligibility, Claim Status Inquiry)	X	X	X	X	X	X*	X	X
Change or add vendor, billing service, or clearinghouse	X	X	X	X		X*	X	X
Add new provider to existing submitter profile	X	X	X	X		X*	X	X

* Applicable if using a billing service or clearinghouse

Questions?

Questions regarding the Part B EDI Customer Profile and EDI Enrollment Form may be directed to EDI Support at 866.352.1608

INCOMPLETE / INCORRECT APPLICATIONS WILL BE RETURNED.

Medicare Part B EDI Customer Profile

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<input type="radio"/>	Claim Status Inquiry Format: ANSI X12N 276/277 v. 4010A1 Batch mode only
	Software for this function is not available from CIGNA Government Services Vendor Name _____ PB _____ Submitter ID # _____

(6) Third-Party Authorization

*** In order for CIGNA Government Services (CGS) to release confidential Medicare information to billing services and/or clearinghouses, Section 6 must be completed.**

Effective immediately, I hereby authorize CIGNA Government Services to release the following data, which contains confidential Medicare information to

_____ as they will be submitting my initial claims.

(Billing Service and/or Clearinghouse Name and Stratus Mailbox ID)

Check only those items that apply: *

- Electronic Receipt Listings (ERLs) and Standardized Error Reports**
- Electronic Remittance Notices (ERNs)**
- Beneficiary Eligibility**
- Claim Status Inquiry**

(7) EDI Number and Password Requirements

The CMS's requirements for EDI access are located in Chapter 24 of Pub.100-04. Section 2.9.10 of the Core Security Requirements (CSR) in the Business Partners Systems Security Manual contains further requirements applicable to use of passwords issued to permit system access. The password requirements apply to entities to which Medicare contractors issue passwords, as well as to Medicare contractors themselves.

An entity that is not a clearinghouse as defined by the Health Insurance Portability and Accountability Act (HIPAA), a provider's agent for preparation and submission of claims to Medicare, or otherwise contracted by a provider to perform a Medicare-covered EDI function, is permitted to perform data analysis and issue reports to a provider, as long as the following requirements are met:

1. A signed agreement must be in effect between the provider and the entity authorizing this entity to use the data and specifying how the data may and may not be used;
2. The entity has furnished the provider with a signed confidentiality agreement that meets Medicare's privacy and security requirements for protection of the personally identifiable beneficiary health data;
3. The provider has notified the patients that their personally identifiable health data will be shared with the entity and how it will be used;
4. The provider agrees not to furnish data to the entity for any patients who object; and
5. The data is forwarded to the entity by the provider.

An entity that does not perform functions for which Medicare EDI data is collected or issued may NOT be given an EDI number or password for direct access to Medicare data, and is never permitted to use a provider's EDI number or password for that or any other purpose. Furthermore, entities that do perform a listed function must never access Medicare systems using a number not directly issued them by the Medicare contractor to whom the provider they represent submits claims. As stated in CSR 2.9.10, passwords are "unique for specific individuals" and must be "controlled by the assigned user and [are] not subject to disclosure."

An entity involved only in transmission of Medicare EDI data between a provider and Medicare is not permitted to open the electronic envelope of the transmitted data, or to generate reports that include data from within those transmission envelopes. Billing agents and business associates that perform other listed functions are permitted to open the electronic envelopes, and use the data for analysis and generation of reports for the providers they serve.

Medicare Part B EDI Customer Profile

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(8) Special Instructions (Briefly describe changes you are requesting)

(9) Provider Signature

*In addition to all of the above, I, the **provider** certify that the information that is provided is accurate to the best of knowledge, and that I have read and understand the security requirements, and acknowledge that it is my responsibility to notify CIGNA Government Services in advance and in writing if I wish to make any changes.*

Provider Name

(Please print)

Provider Signature

(Please include your job title)

Date Signed

IMPORTANT: The provider must sign this form. Other signatures may result in a delay in processing this Medicare Part B EDI Customer Profile. Please send the completed form with signature to the address below.

Return the completed Part B EDI Customer Profile to:

**CIGNA Government Services
ATTN: EDI Department
4135 Mendenhall Oaks Parkway
Suite 101
High Point, NC 27265
Toll-Free: 866.352.1608
Fax: 336.821.4595**

*** INCOMPLETE APPLICATIONS WILL BE RETURNED ***

**ELECTRONIC DATA INTERCHANGE (EDI)
ENROLLMENT FORM**

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers or FIs.

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 carriers or FIs, 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 carrier or FI 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 (submitter identifier) of the provider on each claim electronically transmitted to the carrier or FI;
10. That the CMS-assigned unique identifier number (submitter identifier) 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 carrier or FI, shall not be used by agents, officers, or employees of the billing service except as provided by the carrier or FI (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 carrier or FI or CMS within two 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 FI/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 carrier or FI may require the provider to purchase any or all electronic services from the carrier or FI or from any subsidiary of the carrier or FI or from any company for which the carrier or FI has an interest. The carrier or FI 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 carriers or FIs 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 carrier or FI sells directly, or indirectly, or by arrangement;
6. Notify the provider within two 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 carrier or FI. 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.

Provider's Name _____

Title _____

Address _____

City/State/Zip _____

By _____

Title _____

Date _____