

Payer Agreement Instructions for New Mexico Medicare - MR076

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

Guidelines for completing: New Mexico Medicare- Payer ID MR076

Attachment E-EDI Enrollment Form

Field	Instructions
<i>Section C. Entry Fields</i>	Complete all entry fields as labeled
<i>Section C. Signature</i>	This agreement must be signed with the <i>original</i> signature of the provider or authorized agent. Stamped signatures will not be accepted.

Attachment G- Letter of Authorization

Field	Instructions
<i>Provider or Facility Name</i>	Enter name here
<i>Provider or Group Number</i>	Enter your Medicare number for this payer
<i>Provider Submitter Number</i>	Enter your current submitter ID
<i>Billing Agent/Clearinghouse Name and Submitter Number</i>	Pre-Filled
<i>Effective Date</i>	See note on form regarding effective date.
<i>Signature</i>	This letter must be signed with the <i>original</i> signature of the provider or authorized agent. Stamped signatures will not be accepted.
<i>Printed Name</i>	Printed name of the signer
<i>Title</i>	Title of person signing
<i>Date</i>	Date signed

Return the completed Agreement to the Payer:

EDI-4BCS
ABCBS
601 S. Gaines St.
Little Rock, AR 72203



ATTACHMENT E

EDI ENROLLMENT FORM

Below is the EDI agreement, which is a required component of the entire enrollment packet for a provider submitting claims electronically, as stipulated by the Centers for Medicare and Medicaid Services.

The Provider agrees to the following provisions for submitting Medicare claims electronically to 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.



ATTACHMENT E – Cont'd

E D I E N R O L L M E N T F O R M

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 Health Care Financing Administration Agrees To:

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.



ATTACHMENT E – Cont'd

EDI ENROLLMENT FORM

- 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

Provider's Medicare Provider Number

Provider's Title

Provider's Facility Name

Provider's Physical Address

City, State, Zip

Signature
etc.)

Title
(Provider, Claims Administrator, Office Manager,

Printed Name of Above Signer

Daytime Telephone Number

ATTACHMENT G - LETTER OF AUTHORIZATION

Network Service Access of Medicare Systems – TO BE COMPLETED BY PROVIDER

Please complete the form below and return by mail to the address located at the bottom of this page. Faxed copies will not be accepted, as original signatures are required for our records.

This document is for the purpose of authorizing someone other than the Provider to access Medicare Systems on the Provider’s behalf. All fields must be completed, and failure to include all necessary information may result in the rejection of this letter. An original signature is required from the Provider, CEO, CFO, COO or other duly authorized senior officer of Facility/Clinic.

Provider or Facility Name	
Provider or Group Number	
Provider Submitter Number	

Billing Agent or Clearinghouse Name	
Billing Agent or Clearinghouse Submitter Number	
Effective Date	

Select the date you want to begin submitting your claims through this clearinghouse. Please be prepared to make your changes on the date you have indicated.

By my signature below, I authorize the above named Billing Agent or Clearinghouse to access Medicare systems on behalf of the above named Provider.

Signature

Printed Name

Title

Date

- ACCEPTED BY RETURN MAIL ONLY -

EDI – 4BCS
ABCBS
601 S. Gaines St.
Little Rock, AR 72203