

## ERA Payer Agreement Instructions for Ohio Medicare - MR033

### Important Notes

ERA transactions are available as an additional ProxyMed contracted service. To add ERAs to your contract please contact your ProxyMed Sales person or Account Manager. ERAs must be part of your ProxyMed contract BEFORE completing this ERA Payer Agreement.

Electronic Funds Transfer (EFT) is an arrangement between the Provider and the Payer. ProxyMed does not manage or transmit EFTs.

Before receiving ERAs from this Payer the Provider will need to:

- Be enrolled with the payer and have a valid Provider Identification Number (PIN) before completing the ERA Enrollment Request.
- To obtain a PIN for a specific payer, **the provider or Billing Service** must contact the payer's Provider Relations Department. ProxyMed, Inc. **cannot** make this request for the provider.

### Guidelines for completing: Ohio Medicare Payer ID MR033

- Submit one ERA Payer Agreement for each Physician/Group Tax ID.
- Once the agreement is open in Adobe Reader you can type information onto the form.
- If your practice is currently submitting claims electronically, please disregard the first (2) pages of this agreement.
- Complete the EDI Change Request Form only to be setup for ERA's.

### **EDI Change Request Form**

Field	Instructions
<i>Section: A,B,C Provider Name, Provider Number, Provider Address (Where services are rendered)</i>	Self explanatory
<i>Section D: Current Submitter Code::</i>	Pre-filled by Proxymed
<i>Section E1.Address::</i>	Complete <b>only</b> if address has changed
<i>Section E2. Remittance:</i>	Pre-filled by Proxymed
<i>Section E3. Compression:</i>	Pre-filled by Proxymed
<i>Section E4.Contact Name &amp; Phone Number</i>	Complete <b>only</b> if this information has changed
<i>Section E5. Software Vendor</i>	NA
<i>Section E6.Billing Company/Clearinghouse</i>	Pre-filled by Proxymed
<i>Section F: Valid Authorized Signature</i>	This form must be signed by an authorize agent of the practice. Ohio Medicare will not process your request for ERA's without a valid signature.

*Return ERA Request form to Payer:*

**Payer fax**

(614) 473-6802

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

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.
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 Section 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 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.





### Palmetto GBA OH/WV EDI Change Request Form

(See Attached Instructions)

A) Provider Name: \_\_\_\_\_

B) Provider Number: \_\_\_\_\_

C) Provider Address:  
(Where services are rendered) \_\_\_\_\_  
\_\_\_\_\_

D) Current Submitter Code (If Known): \_\_\_\_\_

E) Please check all that apply:

1)  Address \_\_\_\_\_  
\_\_\_\_\_

2)  Remittance \_\_\_\_\_ Yes \_\_\_\_\_ No

3)  Compression \_\_\_\_\_ Yes \_\_\_\_\_ No  
a) If yes please indicate what type of compression  
\_\_\_\_ PKZIP \_\_\_\_ UNIX \_\_\_\_ GZIP

4)  Contact Name & Phone Number \_\_\_\_\_

5)  Software Vendor \_\_\_\_\_  
a) Will this replace/deactivate all current billing arrangements? \_\_\_\_ Yes \_\_\_\_ No

6)  Billing Company/Clearinghouse \_\_\_\_\_  
a) Will this replace/deactivate all current billing arrangements? \_\_\_\_ Yes \_\_\_\_ No

Please Note: If there is a change with the Billing Company/Clearinghouse or there is a request for electronic remittance, please provide a valid signature from the attachment (page 3).

F) \_\_\_\_\_

\_\_\_\_\_  
Authorized Provider Signature (See attachment)

Title

\_\_\_\_\_  
Print Name of Authorized Provider Signature

**Please Note: The information provided only pertains to changes for the Medicare EDI department. This information will not be forwarded to our Provider Enrollment area.**

### Palmetto GBA