

Pennsylvania Medicare – Payer ID MR027 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: Pennsylvania Medicare – MR027

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

Mailing Address:

Highmark Medical Services, Inc. – EDI 1BL2
P.O. Box 890011
Camp Hill, PA 17089-0011

Electronic Data Interchange (EDI) Setup Requirements - For First Time and Existing EDI Customers

Section	Instructions
Sections A – G	Complete these sections.
Sections H – J	Pre-filled. No entry required.
Section K	Complete and sign. This agreement must be signed with the original signature of the provider or authorized officer. Stamped signatures will not be accepted.

Electronic Data Interchange (EDI) Agreement Form – For First Time EDI Customers

Section	Instructions
Section C. Signature	Read the agreement and complete the bottom-right section. This agreement must be signed with the original signature of the provider or authorized officer. Stamped signatures will not be accepted.

Once the Medicare form(s) has been completed and mailed 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: _____ Billing Service Tax
ID: _____ (If applicable) (If applicable)
applicable)

<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

EDI Enrollment Instructions

All Providers, Vendors, Billing Services and Clearinghouses must enroll with Highmark Medicare Services Inc. for electronic billing. Determine if you are a first time EDI Customer, an Existing EDI Customer or a Vendor, Billing Service or Clearinghouse, and complete the appropriate forms using the respective instructions below.

Any Vendors, Billing Services and Clearinghouses not enrolled with Highmark Medicare Services Inc. will need to complete the 8275 and 8276 forms. EDI Enrollment forms from Providers will not be processed until their Vendor, Billing Service and/or Clearinghouse is enrolled.

First Time EDI Customers

If you are **not** currently an electronic biller with Highmark Medicare Services Inc. and want to enroll to become an electronic biller, you must complete the following forms:

- ▶ Electronic Data Interchange (EDI) Agreement Forms (8275)
- ▶ Electronic Data Interchange (EDI) Setup Requirements (8276)
- ▶ If you want to receive Electronic Remittance Advice (ERA), which is an electronic version of the Standard Paper Remittance (SPR), you also need to complete the Electronic Remittance Advice (ERA) Enrollment Form (8262).

Existing EDI Customers

If you are currently an electronic biller with Highmark Medicare Services Inc. and want to change your EDI enrollment status (e.g., to change software vendors, use a billing service or clearinghouse, to obtain a new Submitter ID, etc.), you must complete the following forms:

- ▶ Electronic Data Interchange (EDI) Setup Requirements (8276)
- ▶ If you want to receive Electronic Remittance Advice (ERA), which is an electronic version of the Standard Paper Remittance (SPR), you also need to complete the Electronic Remittance Advice (ERA) Enrollment Form (8262).

COMPLETION INSTRUCTIONS FOR VENDORS, BILLING SERVICES AND CLEARINGHOUSES

(Companies Only):

When completing the 8275 and 8276, type or print the information for the Vendor, Billing Service or Clearinghouse whenever the form requests Group, Physician, Provider or Supplier Information. The 8275 should contain the company name, address, and authorized signature information. The 8276 should contain the company information in blocks A, B, C, D, E, F, and G. Block J should contain the type of company (Vendor, Billing Service or Clearinghouse) and should contain the Authorized Official information from the Vendor, Billing Service or Clearinghouse.

COMPLETION INSTRUCTIONS FOR THE EDI AGREEMENT FORM (8275)

1. Read the contract.
2. Type or print the Medicare provider transaction access number (PTAN) of the group, physician, provider, or supplier enrolling for EDI. **If you are requesting approval for multiple Provider Transaction Access Numbers (PTAN), a separate EDI Form must be completed for each provider number/practice. If you are billing under a Group PTAN, only one EDI Form should be completed using the Group PTAN. The number reported must match the number on file at Medicare for the group, physician, provider, or supplier name listed on the form.**
3. Type or print the name of the group, physician, provider, or supplier enrolling for Electronic Data Interchange (EDI). **The name listed must match the name on file at Medicare for the provider number listed on the form.**
4. Type or print the National Provider Identifier (NPI) of the group, physician, provider, or supplier enrolling for EDI.
5. Type or print the address, including suite/building numbers/levels, of the group, physician, provider or supplier enrolling for EDI. This address must match the address on file at Medicare for the provider number listed on the form.
6. Sign the form. The signature must contain an original signature from the individual provider, or in the case of a group or other entity, an original signature from one of the providers in the group or an authorized official. An authorized official is an appointed official to whom the supplier has granted the legal authority to enroll it in the Medicare program, to make changes/and/or updates to the supplier's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the supplier to fully abide by the laws, regulations, and the program instructions of Medicare. The authorized official must be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of five percent or more of the supplier (see Section 5 of the 855 Enrollment Form for a definition of "direct owner"), or must hold a position of similar status and authority within the supplier's organization. Signature stamps are not acceptable; blue ink is recommended.
7. Type or print the date the form was signed.
8. Type or print the name and title of the person who signed the form.

FIELD	COMPLETION INSTRUCTIONS FOR THE EDI SETUP REQUIREMENTS FORM (8276)
Check Box	✓ Check one box to indicate Part A or Part B and check one box to indicate the State contract.
Ⓐ	Type or print the name of the group, physician, provider, or supplier enrolling for Electronic Data Interchange (EDI). The name listed must match the name on file at Medicare for the Provider Transaction Access # (PTAN) listed in Block G.
Ⓑ	Type or print the address, including suite/building numbers/levels, of the group, physician, provider, or supplier enrolling for EDI. The address must match the address on file at Medicare for the PTAN listed in Block G.
Ⓒ	Type or print a contact person in your office that has the knowledge and authority to answer questions regarding your enrollment.
Ⓓ	Type or print the telephone number (including area code) of the contact person listed in Block C.
Ⓔ	Type or print the FAX number (including area code) for the group, physician, provider, or supplier enrolling for EDI.
Ⓕ	Type or print the office internet e-mail address for the group, physician, provider, or supplier enrolling for EDI. This will be used to enroll in the EDI ListServ.
Ⓖ	<ul style="list-style-type: none"> ▶ Type or print the National Provider Identifier (NPI) of the group, physician, provider, or supplier enrolling in EDI. The Medicare PTAN and the NPI are required and must match the number on file at Medicare. ▶ Type or print the Medicare Provider Transaction Access Number (PTAN) of the group, physician, provider, or supplier enrolling for EDI. If you are requesting approval for multiple PTANs, a separate EDI Form must be completed for each provider number/practice. If you are billing under a Group PTAN, only one EDI Form should be completed using the Group PTAN. The number reported must match the number on file at Medicare for the group, physician, provider, or supplier name listed in Block A. ▶ Part A only - Type or print the Affiliated Provider numbers.
Ⓗ	<p>Check the appropriate box based on your enrollment needs.</p> <ul style="list-style-type: none"> ✓ Check the "Assign this provider..." option if you are requesting a new electronic billing submitter number. ✓ Check the "Add this provider..." box if you want to add a provider to an already existing submitter number and login ID, and type or print the submitter number and login ID on the corresponding line. <p>NOTE: If you are updating your electronic billing profile (i.e., changing software vendors, etc.), check this box and type or print the existing submitter number and login ID on the corresponding line.</p> <ul style="list-style-type: none"> ✓ Check the "Direct Data Entry" box if you are a Part A customer and not sending the X12N 837 file.
Ⓘ	Check the appropriate box to indicate the correct modem protocol. If you are not sure, contact your vendor for verification. (MCE customers must use Hayes/Z-Modem.) If neither box is checked, the protocol will be defaulted to Hayes/Z-Modem.
Ⓙ	Type or print the name and complete address of your vendor and/or billing service, and/or clearinghouse. If you are using (or enrolling to use) either of the free Medicare software packages, Medicare Claims Express (MCE) or PC-ACE PRO32, check the appropriate box for the vendor and list the billing service name/address, if applicable. To enroll for PC-ACE, you must also complete and return the PC-ACE Agreement Form (8287) and/or the EDI Setup Requirements Form (8276). To enroll for MCE, you must also complete and return the MCE Agreement Form (8726) along with the EDI Agreement Form (8275) and/or the EDI Setup Requirements Form(8276).
Ⓚ	<p>Read the contract, then complete and sign.</p> <ul style="list-style-type: none"> ▶ Sign the form. The signature must contain an original signature from the individual provider, or in the case of a group or other entity, an original signature from one of the providers in the group or an authorized official. An authorized official is an appointed official to whom the supplier has granted the legal authority to enroll it in the Medicare program, to make changes/and/or updates to the supplier's status in the Medicare program (e.g., new practice locations, change of address, etc.), and to commit the supplier to fully abide by the laws, regulations, and the program instructions of Medicare. The authorized official must be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of five percent or more of the supplier (see Section 5 of the 855 Enrollment Form for a definition of "direct owner"), or must hold a position of similar status and authority within the supplier's organization. Signature stamps are not acceptable; blue ink is recommended. ▶ Type or print the name and title of the person who signed the form. ▶ Type or print the date the form was signed.
Ⓛ	<p>Unless a written request is provided asking to maintain an existing submitter number, Medicare will remove the old submitter number before assigning a new submitter number.</p> <p>Caution: Multiple submitter numbers may cause posting problems with your ERA for Part B customers. Multiple submitter numbers are not permitted for Part A customers and are strongly discouraged for Part B customers.</p>

Note: To enroll for Electronic Remittance Advice (ERA), which is the electronic version of the Standard Paper Remittance (SPR), complete the ERA Enrollment Form (# 8262) and mail it to Medicare EDI Services with the 8275 and/or 8276 application(s).

If you have any questions or require assistance with the enrollment process, please contact an EDI Analyst at (866) 488-0546, option 2 for Part A customers and option 1 for Part B customers.

Mail the Completed EDI Enrollment Form(s) and any additional, applicable forms to:

Highmark Medicare Services Inc. - EDI
P.O. Box 890011
Camp Hill, PA 17089-0011



Electronic Data Interchange (EDI) Agreement Form

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

A. The Provider Agrees:

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS cont 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, DMERCs, FIs or another contractor if so designated by CMS, 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, DMERC, FI, or other contractor if designated by CMS 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 (submitter identifier) of the provider on each claim electronically transmitted to the carrier, DMERC, FI, or other contractor if designated by CMS.
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, DMERC, FI or other contractor if designated by CMS, shall not be used by agents, officers, or employees of the billing service except as provided by the carrier, DMERC, or FI (in accordance with 1106(a) of the Social Security Act).
14. That it will research and correct claim discrepancies.
15. That it will notify the carrier, DMERC, FI or other contractor if designated by CMS or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. The Centers for Medicare & Medicaid Services (CMS) will:

1. Transmit to the provider an acknowledgement of claim receipt.
2. Affix the fiscal intermediary/carrier/DMERC or other contractor if designated by CMS. 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 carrier, DMERC, FI or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, DMERC or FI or from any subsidiary of the carrier, DMERC, FI or other contractor if designated CMS or from any company for which the carrier, DMERC or FI has an interest. The carrier, DMERC, FI or other contractor if designated by CMS 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, DMERCs, FIs, or another contractor if so designated by CMS 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, DMERC, FI or other contractor if designated by CMS 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 the carrier, DMERC, FI or other contractor if designated by CMS. 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. Read, Complete, and Sign: (Please print or type in blue or black ink)

Any provider enrolling to submit Medicare claims, electronically to CMS or its contractors remains responsible for those claims as those responsibilities are outlined on the Electronic Data Interchange Agreement Form (8275). In accepting claims submitted electronically to the Medicare Program from any billing service or through the use of a particular product which accomplishes this process, neither CMS, nor any other Medicare Contractors are attesting to the appropriateness of the methods used by the billing service/clearinghouse or to the accuracy of a particular vendor's product which purportedly facilitates such electronic submissions. The provider furnishing the item or service for whom payment is claimed under the Medicare Program retains the responsibility for any claim regardless of the format in which it chooses to submit the claim.

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions contained within the Electronic Data Interchange Agreement Form (8275) and acknowledge same by signing below. An authorized official is an appointed official to whom the supplier has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the supplier's status in the Medicare Program (e.g., new practice locations, change of address, etc.), and to commit the supplier to fully abide by the laws, regulations, and the program instructions of Medicare. **The authorized official must be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of five percent or more of the supplier (see Section 5 of the 855 Enrollment Form for a definition of "direct owner"), or must hold a position of similar status and authority within the supplier's organization.**

(Must be the same as Block G) ▶ Medicare Provider Transaction Access Number (PTAN):	
Name of Group, Physician, Provider, or Supplier	NPI Number
Address of Group, Physician, Provider, or Supplier (<i>street</i>)	
Address of Group, Physician, Provider, or Supplier (<i>city, state, zip</i>)	
Authorized Signature	Date
Printed Name of Authorized Signature	Title

Complete, Sign & Return to: Medicare EDI Services, EDI Coordinator, P.O. Box 890011, Camp Hill, PA 17089-0011



ELECTRONIC DATA INTERCHANGE (EDI) SETUP REQUIREMENTS

CHECK ONE: Part A (Institutions) Part B (Professionals) **CHECK ONE STATE:** DC DCMA DE MD NJ PA

A NAME OF GROUP, PHYSICIAN, PROVIDER, OR SUPPLIER (Must match the name on file at Medicare for the Provider Number listed in Block G.) _____

B STREET ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____

C CONTACT PERSON **D** TELEPHONE NUMBER **E** FAX NUMBER **F** E-MAIL ADDRESS FOR LISTSERV _____

G NPI # _____ **Provider Transaction Access Number (PTAN)** _____
For Affiliated PTAN #'s, attach list on company letterhead, if needed (Part A only).

H **Please check one:** (Requests will be processed as ANSI ASC X12N Version 4010.A1, the HIPAA-compliant format/version.)
 Assign this provider a new electronic billing Submitter ID.
 Add this provider to existing Submitter ID _____ and PRJ _____
 Direct Data Entry (Part A). I do not need a billing Submitter ID.

I **PLEASE CHECK MODEM PROTOCOL:** HAYES/Z-Modem (Default option if PC-ACE/MCE or blank.) MNP

J **COMPLETE THE VENDOR, BILLING SERVICE, AND/OR CLEARINGHOUSE INFORMATION:**
 PC-ACE PRO-32 (Only check if enrolling for the Medicare-issued software. If enrolling for PC-ACE PRO-32, the PC-ACE PRO-32 Agreement form (8287) is required.)
 MCE (Only check if enrolling for NJ and PA Part B Medicare-issued software. If enrolling for MCE, the MCE Agreement Form (8726) is required.)
 Name of Software Vendor and phone number: _____
 Vendor Street Address, City, State, and Zip: _____
 Name of Billing Service and phone number: _____
 Street Address, City, State, and Zip: _____
 Name of Clearinghouse and phone number: _____
 Street Address, City, State, and Zip: _____

To enroll for Electronic Remittance Advice (ERA), you must complete Form 8262. To disenroll for ERA, contact an EDI Analyst.

K **Read, Complete, and Sign:** (Please print or type in blue or black ink)

Any provider enrolling to submit Medicare claims, electronically to CMS or its contractors remains responsible for those claims as those responsibilities are outlined on the Electronic Data Interchange Agreement Form (8275). In accepting claims submitted electronically to the Medicare Program from any billing service or through the use of a particular product which accomplishes this process, neither CMS, Highmark Medicare Services Inc. nor any other Medicare contractor is attesting to the appropriateness of the methods used by the billing service/clearinghouse or to the accuracy of a particular vendor's product which purportedly facilitates such electronic submissions. The provider furnishing the item or service for whom payment is claimed under the Medicare Program retains the responsibility for any claim regardless of the format in which it chooses to submit the claim.

Any provider that contracts to submit/receive transactions electronically using a billing agent or a clearinghouse/network service vendor, carriers, DMERC's, FIs or any other contractors as designated by CMS must have an agreement signed by that third party indicating the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. Providers are not permitted to share their personal EDI access number and password with any billing agent, clearinghouse/network service vendor; to anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility, or to determine the status of a claim; and that no other non-staff individuals or entities may be permitted to use a provider's EDI number and password to access Medicare systems.

Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate. Medicare reserves the right to terminate this arrangement if there is no EDI activity within a six (6) month period.

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions contained within the Electronic Data Interchange Agreement Form (8275) and acknowledge same by signing below. An authorized official is an appointed official to whom the supplier has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the supplier's status in the Medicare Program (e.g., new practice locations, change of address, etc.), and to commit the supplier to fully abide by the laws, regulations, and the program instructions of Medicare. **The authorized official must be the supplier's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of five percent or more of the supplier (see Section 5 of the 855 Enrollment Form for a definition of "direct owner"), or must hold a position of similar status and authority within the supplier's organization.**

AUTHORIZED OFFICIAL: Original Signature	Printed Name	Title	Date Signed
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FOR OFFICE USE ONLY: DO NOT WRITE IN THIS SPACE Part A <input type="checkbox"/> Part B <input type="checkbox"/> <input type="checkbox"/> DC <input type="checkbox"/> DCMA <input type="checkbox"/> DE <input type="checkbox"/> MD <input type="checkbox"/> NJ <input type="checkbox"/> PA LOGON _____ VERSION _____ TO _____	L PLEASE READ CAREFULLY AND COMPLETE, AS APPROPRIATE If the provider number listed in Block G is associated to any other submitter number(s), Medicare will remove the other submitter number(s) before assigning a new submitter number. The following information is for PART B ONLY: If a provider is associated to a submitter number, the provider can maintain the submitter number for 45 days by including a signed, written letter requesting to keep the submitter number for 45 days. After 45 days, Medicare will remove the submitter number from the provider without notice. Multiple submitter numbers are not permitted after the initial 45-day time period.
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