



Enrollment Department
MedAvant
1854 Shackleford Court
Suite 200
Norcross, GA. 30093-2954

Phone: (800) 792-5256 Option 1
Fax: (404) 877-3324
provider.enrollment@MedAvanthealth.com

Noridian Payer Agreement Instructions

Alaska Medicare MR010
Arizona Medicare MR008
Colorado Medicare MR004
Hawaii Medicare MR057
Iowa Medicare MR036
Nevada Medicare MR007

North Dakota Medicare MR083
Oregon Medicare MR011
South Dakota Medicare MR084
Utah Medicare MR046
Washington Medicare MR006
Wyoming Medicare MR074

Are you set up with your 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

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

MedAvant's Claims Enrollment Form

- Please complete a MedAvant Claims Enrollment Form for each Tax ID and fax it to MedAvant at: (404) 877-3324.
- This form can be used if you are enrolling with one or more new Payer(s) or if you are enrolling a new rendering provider with your existing Payer(s).
- Go to: <http://www.medavanthealth.com/payerlist/downloads/claimsenrollmentform.pdf>

Payer Enrollment Form

- Some Payers require original forms.
- If the payer accepts copies, be sure to include all pages of this agreement and verify they are legible.
- Submit one agreement for each Group ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 3 - 4 weeks.

Payer Approval

- In some cases a payer will send you an approval letter but they will not notify us. If you receive payer approval you must let us know. You can call, fax or email a copy of the approval letter to MedAvant Enrollment. Our contact information is listed above.
- **DO NOT** transmit your claims until you receive an approval notice from MedAvant or your claims will reject.



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Guidelines for completing: Noridian Medicare

When you have completed this Agreement please mail it to Noridian at:

EDI Support Services
 PO Box 6729
 Fargo, ND 58108-6729

4010A1 Professional Claim Registration Form (837P)

Intentions (1)	Instructions
<i>Check box</i>	Check box to indicate this a new registration or updating information
Provider Information (2,3,4,5)	Instructions
<i>Date</i>	Effective date of agreement.
<i>Federal Tax ID/SSN and NPI</i>	Self explanatory
<i>Lines of Business</i>	State and Line of Business is pre-filled. Enter your Billing Provider/Group #
Facility Information (6)	Instructions
<i>Facility Information</i>	Complete information for the Practice/ Provider.
Vendor Information (7)	Instructions
<i>Clearinghouse Information</i>	Pre-filled. No entry required
<i>ERA (8)</i>	Not applicable. No entry required
<i>Method of Electronic Access (9)</i>	Pre-filled. No entry required
Signature (10)	Instructions
<i>Signature</i>	Original ink signature of the provider or someone with a management position or higher. If this is a provider/facility with a group provider/clinic number, signature must be someone with the authority to enter into contracts on behalf of the group. BLUE INK IS PREFERED and stamped signatures are not acceptable.
<i>Print Name</i>	Print name of person signing
<i>Title</i>	Title of person signing
<i>Date</i>	Date signed



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Electronic Data Interchange (EDI) Enrollment Form - Section C

Field	Instructions
<i>Provider Name & Telephone Number</i>	Self explanatory
<i>Medicare Provider/Group Number</i>	If your practice has a group Medicare number, please use that number.
<i>Title</i>	Title of the individual who completes the agreement for the practice/provider
<i>Address, City, State, Zip</i>	Self explanatory
<i>Authorized Signature</i>	Original signature of the provider or authorized representative is required. If this is a group only one signature is needed. BLUE INK IS PREFERED and stamped signatures are not acceptable.
<i>Title</i>	The title of the provider. If you list a group name on the agreement as the provider name then leave this field blank.
<i>Date</i>	Date signed

Provider Transaction Termination/Change Form- (This form is used **only** if your if you are currently billing through another Clearinghouse.)

Field	Instructions
<i>Form Objective</i>	<i>Pre-filled by MedAvant.</i>
<i>Facility Information</i>	Self explanatory
<i>Change in sender or receiver information</i>	Pre-filled by MedAvant
<i>Valid Signature</i>	Name of the individual who is authorized to complete the agreement for the practice/provider
<i>Title</i>	Title of the individual who completes the agreement for the practice/provider
<i>Date</i>	Date signed

Billing Service Information

Billing Service Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Contact: _____

Phone Number: _____ Fax Number: _____

Clearinghouse Information

Clearinghouse Name: _____

Mailing Address: _____

City: _____ State: _____ ZIP: _____

Contact: _____

Phone Number: _____ Fax Number: _____

8. Do you want to receive an Electronic Remittance Advice (ERA***)?

(If yes, fill out the Exhibit A, 835 Health Care Claim Payment/Advice Form at <http://www.edissweb.com/docs/cgp/835.pdf>.)

*** An ERA is an electronic copy of the payment data received on the paper remittance. You must have a software program to print or post this data. You can get free software on our web site at www.edissweb.com.

9. Method of Electronic Access

If dial-up, select protocol

SIGNATURE

10. The completed form with an authorized signature may be either mailed or faxed to EDISS.

As a member of this organization, I have the authority to enter into, administrate, and/or terminate contracts and make related determinations. By signing this document I verify I meet the signature requirements and authorize the set-up noted above for the 837P Professional Claim transaction.

Signature _____
Signed By

Type Name: _____

Title: _____

Date: _____

Electronic Data Interchange (EDI) Enrollment Form

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

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contractor 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-signed 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 (submitted identifier) constitutes the provider's legal electronic signature and 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 whom is represents 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 Social Security Act (the 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 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 acknowledgement of claim receipt;

2. Affix the FI/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' 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 by CMS, or from any company for which the carrier, DMERC, FI, or other contractor if designated by CMS 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, DMERC, FIs, or other contractor if 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 two business days if any transmitted data are received in an unintelligible or garbled form.

NOTE: 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 carrier, DMERC, FI, or other contractor if designated by CMS. 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 EDI Enrollment Form 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 Telephone Number

 Medicare Provider/Group Number

 Title

 Address

 City/State/Zip

 Authorized Signature

 Title

 Date

NOTE: Any provider using the services of a billing agent/clearinghouse/network services vendor to submit/receive transactions electronically is required to have an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regards to viewing or use of Medicare beneficiary data (not to be submitted to the carrier but are to be retained by the provider).

CMS instructions allow release of eligibility data to providers or their authorized billing agents for the purpose of preparing an accurate claim. Such information may not be disclosed to anyone other than the provider, supplier, or beneficiary for whom the claim was filed.

NOTE: Please fax both pages of this completed EDI Enrollment Form to EDI Support Services at 877-269-1472 or mail to PO Box 6729, Fargo, ND 58108-6729.