

Texas (MR005), Maryland (MR038), DC Metro (MR038), Virginia (MR022), Delaware (MR039 )  
Medicare Agreement Instructions

## **Instructions for Payer Agreements to Submit Electronic Claims**

### **Important Note:**

Before a provider completes an agreement for electronic claims processing, the provider **must be enrolled with the payer and have a valid Provider Identification Number (PIN).**

### **EDI Provider Information Form**

- Section A- Complete all information
- Section B- Leave Blank
- Section C- This has been completed for you.

### **Medicare Enrollment Data Interchange Enrollment Agreement**

- Read agreement and sign on page 3.

**Send the Agreements to: ATTN: Forms Management  
ProxyMed, Inc  
Suite 200  
1854 Shackleford Ct.  
Norcross, GA 30093**

**Note: If the agreement is not completed properly it will be returned delaying the enrollment and approval process.**

**Please use the NDC Health Carrier Approval Tracking Form to enter method and date agreement was shipped to the Payer.**



*A CMS Contracted Intermediary and Carrier*

Dear Provider,

Thank you for your interest in Electronic Data Interchange (EDI).

Section 1 – contains the **required** enrollment documents that **must be completed**, signed and returned to our office prior to initiation of electronic claims submission or inquiry.

Section 2 – contains information regarding various options available to our electronic trading partners. These are not mandatory; they are intended to ensure you are aware of all of the electronic opportunities available to you. If you choose to take advantage of any of these options, simply complete the associated request form and return it along with the enrollment documents. Your request will be processed as quickly as possible. Please allow 2 weeks for processing software requests.

If you have any questions regarding any of the documents in this package, please phone the TrailBlazer EDI Technology Support Center toll-free at 1-866-749-4302.

## TrailBlazer Health Enterprises, LLC New EDI Provider Enrollment Packet Section 1

The following documents are required for electronic data interchange (including electronic claims submission and inquiry):

- ◆ Electronic Data Interchange Provider Information Form (page 3)
- ◆ Medicare Electronic Data Interchange Enrollment Agreement (page 4)

**All new providers *must* complete and return these enrollment documents in order to enroll in Electronic Data Interchange (EDI).** The Medicare Electronic Data Interchange Enrollment Agreement must be signed by the physician, administrator, or equivalent legal representative and the *original* returned prior to sending electronic production claims. The enrollment documents ***must be completed and returned*** to us by mail for processing. **Faxes are *not* acceptable.** You should keep a copy of the Medicare EDI Enrollment Agreement for your records.

If you have any questions, please contact the Technology Support Center toll-free at 1-866-749-4302.

### **ELECTRONIC DATA INTERCHANGE (EDI) PROVIDER INFORMATION FORM**

#### **Part A – Provider Data**

This portion of the form is to be completed by the Physician, Supplier, or Group Practice. It must include the Physician, Supplier, or Group Practice name and the complete street address, city, state, zip code, primary contact's name, phone number, fax number, and provider number(s). If you are requesting approval for multiple physician, supplier, or group identification numbers, a separate EDI Provider Enrollment Packet ***must*** be completed for each individual billing number. If you are enrolling a group practice, only one Enrollment Packet should be completed with the group billing identification number.

**Provider is Submitter:** Place a check before this choice if you will be submitting—

- ◆ Electronically
- ◆ Direct to us from your office
- ◆ Using the software indicated in Part B of the form

This ***must*** be checked if applicable.

**Provider is with Billing Service or Clearinghouse:** Place a check before this choice if your claims will be submitted—

- ◆ Electronically
- ◆ Through a billing service or clearinghouse, as indicated in Part C of the form

This ***must*** be checked if applicable.

**Provider is with other Providers:** Place a check before this choice if—

- ◆ There is more than one physician, supplier, or group in your office
- ◆ You will be submitting electronically, directly from your office

Be sure to include the Provider Identification Numbers in the space provided. With this choice, the group of providers will be assigned one special submitter number to be used by all providers. **Note:** Only individual practice or group numbers are needed. Physician's individual numbers that are within a group billing practice are not needed.

#### **Part B – EDI Software Vendor Data**

If you received this packet from your software vendor, this section may have already been completed for you. If it is not completed, you must provide the company name of your software vendor.

### **Part C – EDI Billing Service or Clearinghouse Data**

If you received this packet from your billing service or clearinghouse, this section may have already been completed for you. If it is not completed, you must provide the company name of the billing service or clearinghouse that will be submitting your claims.

### **MEDICARE ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT AGREEMENT**

The physician, administrator, or equivalent legal representative must sign this agreement if you will be submitting Medicare claims. A copy of this agreement can be found following the EDI Provider Information Form.

### **SUBMITTING COMPLETED DOCUMENTS**

Please make sure you follow these steps:

- Step 1:** Complete the Electronic Data Interchange (EDI) Provider Information Form (page 3).
- Step 2:** Complete and sign the Medicare Electronic Data Interchange (EDI) Enrollment Agreement (page 4).
- Step 3:** Make copies of the completed forms for your records.
- Step 4:** Return all *original* documents to one of the following addresses:

**Mailing Address**  
TrailBlazer Health Enterprises, LLC  
Electronic Data Interchange  
P.O. Box 4898  
Timonium, MD 21094-4898

**Delivery Address**  
TrailBlazer Health Enterprises, LLC  
Electronic Data Interchange  
Timonium II-6th Floor  
1954 Greenspring Drive  
Timonium, MD 21093

It is very important that you complete and return the entire enrollment packet as described above.

***Incomplete packets will not be processed and will be returned to the submitter.***

Once the complete provider enrollment packet has been received, the documents will be processed. Processing will take approximately two weeks from the date of receipt. (Remember that mailing time can take as much as five days.)

After processing, a confirmation will be faxed to the submitter as notification to begin filing claims electronically. If neither confirmation nor a returned packet is received after two weeks, contact the Technology Support Center toll-free at 1-866-749-4302.



**TrailBlazer**  
HEALTH ENTERPRISES, LLC  
EDI Provider Information Form

Date:

**Part A – Provider Data** (to be completed by Provider)

Name:

Address:

City, State, Zip:

Primary Contact:

Phone Number:

Fax Number:

Medicare Provider Number:

Check one of the following:

Provider is Submitter (Provider submits claims directly from their office)

Provider is with Billing Service/Clearinghouse

Provider is with other Providers (list Provider ID #'s: \_\_\_\_\_ )

**Part B – EDI Software Vendor Data** (to be completed by Vendor)

Company Name:

Primary Contact:

Phone:

Fax:

Vendor Code:

Check the format in which you will be submitting:  NSF  UB92  ANSI

Indicate the version number: \_\_\_\_\_

**Part C – EDI Billing Service/Clearinghouse Data**  
(to be completed by Billing Service/Clearinghouse)

Company Name: ProxyMed, Inc.

Primary Contact: Provider Enrollment

Phone: 800-792-5256  
Option 812

Fax: 770-885-4559

Submitter ID: S00558

Password: N/A

Check the format in which you will be submitting:  NSF  UB92  ANSI

Indicate the version number: 4010A1

## Medicare Electronic Data Interchange Enrollment Agreement

Medicare Billing Provider Number \_\_\_\_\_

The undersigned 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
  - 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 §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 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.
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.
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 the 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: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Title: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

By: \_\_\_\_\_

Title: \_\_\_\_\_

Date: \_\_\_\_\_