

## **Payer Agreement Instructions for Trailblazers Medicare**

TX Medicare MR005; VA Medicare MR022  
CO Medicare MR004; NM Medicare MR076  
OK Medicare MR013

### **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.

### **If you currently submit Electronic Claims to this Payer**

If you are on file with this Payer and submit claims to them, you need to complete the Trailblazer EDI Provider Information Form, mail it to the payer (Mailing Address Below) and complete the McKesson Claims Enrollment Form & fax it to McKesson. The Claims Enrollment Form must include your Provider or Group ID.

If you currently submit to this Payer  
Return a cover note and a McKesson Claims Enrollment Form to McKesson

**Fax to McKesson Enrollment**

1-800-633-4763

## Payer Enrollment

### **If you do not submit Electronic Claims to this Payer**

If you have not been set up with this Payer for submitting claims, then complete the attached EDI Provider Information Form and the Medicare Electronic Data Interchange Enrollment Agreement. Return these to the Payer. Complete and fax a McKesson Claims Enrollment Form to McKesson enrollment.

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. McKesson **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 group or provider ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- If you receive an approval letter from the payer, contact us via phone or fax a copy to us. DO NOT transmit your claims until you receive an approval letter from McKesson or your claims will reject.

## 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: Trailblazers Medicare

### **EDI Provider Information Form**

Section	Instructions
Section 1	Complete all fields in this section. The check box is pre-filled.
Section 2	Leave blank. No entry required.
Section 3	Pre-filled. No entry required.
Signature, Printed Name, Date, & Title	Please complete this section as indicated

## Medicare Electronic Data Interchange Enrollment Agreement

Field	Instructions
Section C. Signature	The Provider or someone authorized to sign on behalf of the provider must complete this portion of this agreement. Please be sure to enter the providers Medicare Provider Number and date. Mail this form with <b>original</b> signature to the address below

### **Return the Information Form and the Enrollment Form to the Payer:**

Mailing address for USPS	Physical address for FedEx, UPS, etc.
Trailblazers Health Enterprises, LLC Electronic Data Interchange P.O. Box 100249 Columbia, SC 29209 2300	Trailblazers Health Enterprises, LLC Electronic Data Interchange Building 1 Springdale Drive Camden, SC 29020-1728

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) applicable) (If applicable)

<i>First Name</i>	<i>Last Name</i>	<i>Credential</i>	<i>Specialty</i>	<i>Individual NPI</i>	<i>Group NPI</i>

<b>Practice Name:</b>	
<b>Practice Tax ID:</b>	

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](http://www.lytec.com/download/Phoenix_Payer_List.pdf) for Lytec users or at [http://www.medisoft.com/download/Phoenix\\_Payer\\_List.pdf](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:
<b>Medicare</b>	Ind #	Ind #	Ind #
	Grp #	Grp #	Grp #
<b>Medicaid</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>BCBS</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>TriCare</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>RR Medicare</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>Other</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>Other</b>	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



Dear Provider:

Thank you for your interest in Electronic Media Claims (EMC). Enclosed is a summary of the available electronic claims services for Medicare Part A/B providers. Also enclosed are the necessary applications, enrollment forms and instructions for their completion.

**Section 1 - General Electronic Data Interchange (EDI) Enrollment Documents** – 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 - Free Billing Software**

**Section 3 - Testing Requirements**

We are committed to making your transition to EMC as smooth as possible. If you have any questions regarding the information contained in this package, please feel free to contact the TrailBlazer Health Enterprises<sup>®</sup> EDI Technology Support Center toll free at (866) 749-4302.

**Be Compliant: Take Control of Your Accounts Receivable**

Sign up today to receive your remittances electronically. Download and print your remittances more quickly. CMS is focused on increasing the number of providers who receive their remittances electronically and on decreasing the printing and mailing costs associated with hard copy remittances. Complete your forms today!

**Important Note on Staying Up-To-Date Online**

Register on the TrailBlazer<sup>SM</sup> Web site at <http://www.trailblazerhealth.com> to receive EDI news electronically. By selecting “Listserv” (which displays at the top of all pages) and completing a user profile, you will be notified via e-mail when new or important EDI information is added to the Web site. If you have already registered, please ensure your profile has been updated for all new applicable EDI categories.

## SECTION 1 – GENERAL EDI ENROLLMENT DOCUMENTS

The following documents are required to enroll for EDI:

- **Medicare Electronic Data Interchange Application**  
The purpose of the EDI application is to enroll providers, software vendors, clearinghouses and billing services as electronic submitters. Please follow the instructions carefully when completing the application. Incomplete forms will be returned to the applicant, thus delaying processing.
- **Medicare Electronic Data Interchange Enrollment Agreement**  
The EDI enrollment agreement should be submitted when enrolling for electronic billing. It should be reviewed and signed **only** by the provider to ensure each is knowledgeable of the enrollment request and the associated requirements:
  - If the submitter will be submitting for multiple providers, each provider whose claim data will be submitted must complete this form.
  - The entire form must be read carefully and then dated with the day, month and year.
  - The name of the provider (an authorized officer’s name) must be printed in the space provided and that authorized officer’s title and signature must also be included.
  - When completed, **all three pages** of the properly executed **EDI Enrollment Agreement** must be returned **with** the EDI Application form.

Providers who have contracted with a third party (clearinghouse/network service vendor or a billing agent) are required to have that third party sign an agreement in which they agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. These agreements are not to be submitted to Medicare, but are to be retained by the providers.

Providers are obligated to notify Medicare by hard copy of:

- Any changes in their billing agents or clearinghouses.
- The effective date they will discontinue using a specific billing agent or clearinghouse.
- If they want to begin using additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouses begin to use alternate software. The clearinghouses are responsible for notification in this instance.

**Note:** The binding information in an EDI Enrollment Form does not expire if the person who signed the form for a provider is no longer employed by the provider.

### ***The EDI Application Process***

**Step 1:** Complete the EDI application.

**Step 2:** Complete and sign the Medicare Electronic Data Interchange Enrollment Agreement. The Medicare provider must complete and sign this form.

**Step 3:** Complete documents and mail to the following address:

MAILING ADDRESS	DELIVERY ADDRESS
TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 P.O. Box 100249 Columbia, SC 29209-3249	TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 Building One 2300 Springdale Drive Camden, SC 29020-1728

**Step 4:** Retain the completed forms for your records.

Processing an EDI application will take **five business days** from the date of receipt. When processing is complete, you will receive a notification by e-mail (primary communication method), fax or mail. New electronic submitters and software vendors will be informed of any testing requirements.

### ***Electronic Data Interchange Application Instructions***

**Please retain a copy of this completed form for your records. You must submit a completed EDI application form when submitting additional EDI forms.**

The field descriptions listed below will aid in properly completing the application. Please follow these instructions closely. The Medicare Electronic Data Interchange Application is required. The Multiple Provider List should be used if you are listing additional providers on your application.

Providers are not permitted to share their personal EDI access number (submitter ID) or password with:

- Any billing agent, clearinghouse/network service vendor.
- To anyone on their staffs who has no 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.
- Any non-staff individual or entity.

The EDI submitter ID and password act as an electronic signature; therefore, the provider would be liable if any entity performed an illegal action while using that EDI submitter ID and password. Likewise, a provider’s EDI submitter ID and password is non-transferable, meaning it may not be given to a new owner of the provider’s operation. New owners must obtain their own EDI submitter ID and password.

Form Field Name	Instructions for Field Completion
<b>1. Provider Data</b>	Complete the date, provider’s name, address, primary contact, phone, fax and e-mail address. <ul style="list-style-type: none"> <li>• Check the Part A or Part B Provider indicator box.</li> <li>• Check the appropriate state indicator box.</li> <li>• Indicate the National Provider Identifier (NPI).</li> <li>• Action Requested: Please indicate appropriate request below:                             <ul style="list-style-type: none"> <li>○ Provider is submitter – Provider submits claims directly from his office).</li> <li>○ Provider is with billing service/clearinghouse.</li> <li>○ Provider is with other providers (list provider numbers).</li> <li>○ Remove provider from Submitter ID (provide Submitter ID).</li> </ul> </li> </ul>
<b>2. EDI Software Vendor Data</b>	Indicate the name of the software vendor you will use for electronic claim submission to TrailBlazer. If you will use our free PC-ACE Pro32, write PC-ACE Pro32 in this field. If the vendor ID is known, enter the assigned ID; PC-ACE users may leave this field blank.
<b>3. EDI Billing Service/ Clearinghouse Data</b>	Indicate the name, primary contact, phone, fax and submitter/password of the billing service or clearinghouse that will be communicating with TrailBlazer. <b>Do not forget to sign and date the bottom of the form.</b>



EDI Provider Information Form

<b>1. Provider Data</b>		(To be completed by provider)	Date:
Name:			
Address:			
City, State, ZIP:			
Primary Contact:			
Phone Number:		Fax Number:	
E-mail Address:			
Please Check One: <input type="checkbox"/> Part A Provider <input type="checkbox"/> Part B Provider			
Please Check Applicable State: <input type="checkbox"/> CO <input type="checkbox"/> NM <input type="checkbox"/> OK <input type="checkbox"/> TX <input type="checkbox"/> VA			
NPI (National Provider Identifier):		Provider Number:	
Action Requested:			
<input type="checkbox"/> Provider is Submitter (Provider submits claims directly from their office)			
<input type="checkbox"/> Provider is with Billing Service/Clearinghouse (Section 3 must be completed)			
<input type="checkbox"/> Provider is with other Providers (list NPI #'s: ) _____			
<input type="checkbox"/> Remove Provider from Submitter ID: _____			
<b>2. EDI Software Vendor Data</b>		(To be completed by vendor)	
Company Name:			
Primary Contact:		Phone:	Fax:
Vendor Code:			
<b>3. EDI Billing Service/Clearinghouse Data</b>		(To be completed by billing service/clearinghouse)	
Company Name:			
Primary Contact:		Phone:	Fax:
Submitter ID:		Password:	

I certify that I am legally empowered to sign this form on behalf of the Legal Business Name identified on this form. I acknowledge that in signing this, I bind this company or unincorporated organization to notify the Medicare contractor in advance and in writing if changes have occurred to information reported in this form or if it is necessary to revoke any designations made in the form. I certify that the information I have supplied is accurate. As a Medicare provider/supplier, I understand that in signing this form I am responsible for payment of any fees for EDI services charged by a designated EDI submitter/receiver with whom I have elected to conduct business. I also understand that any acknowledgement, error reports, or query responses related to submitted transactions will be returned to any designated EDI submitter/receiver with whom I have authorized on this form and that Medicare contractors are not permitted to send duplicate copies of outbound transactions to my organization as well as to the designated EDI submitter/receiver.

Signature \_\_\_\_\_ Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Title \_\_\_\_\_

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

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

1. That it will be responsible for all Medicare claims submitted to CMS or a designated CMS contactor 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, MACs, 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, MAC, 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, MAC, FI or other contractor if designated by CMS;
10. That the CMS-assigned unique identifier number (submitter identifier) or NPI 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, MAC or 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, MAC or FI (in accordance with §1106(a) of the Social Security Act (the Act));
14. That it will research and correct claim discrepancies;
15. That it will notify the carrier, MAC or 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 acknowledgment of claim receipt;
2. Affix the FI/carrier/MAC 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, MAC, FI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, MAC, or FI, or from any subsidiary of the carrier, MAC, FI, other contractor if designated by CMS, or from any company for which the carrier, MAC, or FI has an interest. The carrier, MAC, 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, MACs, FIs, or other contractors 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, MAC, FI, or other contractor if designated by CMS sells directly, or 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 the carrier, MAC, 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 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: \_\_\_\_\_

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

\_\_\_\_\_

City/State/ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_

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

By (Print Name): \_\_\_\_\_

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

Date: \_\_\_\_\_ Medicare Provider Number \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

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Complete this form and mail to:

TrailBlazer Health Enterprises, LLC  
EDI Operations, AG-507  
P.O. Box 100249  
Columbia, SC 29209-3249