

**NEW JERSEY MEDICARE MEDICAL****For Initial Enrollment with this payer:**

- If you have NOT submitted claims electronically to this payer, the Payer requires Payer Registration forms. Please complete all fields on the following page(s) as well as the attached Payer Registration forms and return to Emdeon for processing.
- Registration with Emdeon takes 21 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site <http://www.emdeon.com> or by calling our Fax on Demand service at 800-760-2804 (doc# 1085).

**For Re-Enrollment (COS Change of Service) with this payer:**

- If you have submitted claims electronically to this payer in the past, either directly or through another clearinghouse, and would like to submit through Emdeon, the Payer requires payer registration forms.
- Registration with Emdeon takes 21 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site <http://www.emdeon.com> or by calling our Fax on Demand service at 800-760-2804 (doc# 1085).

**If you are already APPROVED by this payer to submit through Emdeon:**

- If you have already received an approval from this payer to submit claims electronically through Emdeon, you must notify Emdeon so that we may process your approval in our enrollment systems. Please submit a **Client Provided Approval Form** to Enrollment for processing.
  - You may obtain the form from our enrollment web site <http://www.Emdeon.com> or by calling our Fax on Demand service at 1-800-760-2804 (doc# 1450).
  - The Client Provided Approval form must be submitted to: [payerregistration@Emdeon.com](mailto:payerregistration@Emdeon.com) , or faxed to 615-885-3713.

**Payer Registration Reminders:**

- Please keep a copy of all forms for your records.
- Please verify that all pages in the agreement are included when mailing.
- Please ensure that all required fields are completed and legible.
- Please provide a physical address below in case we need to Fed-Ex your agreement back to you.
- Please remember to sign and date all documents. Your software vendor must be certified to send All-Payer claims to Emdeon. Please contact your vendor if you have questions regarding certification.
- To obtain forms or additional payer information, visit our website: <http://www.Emdeon.com>.


**NEW JERSEY MEDICARE MEDICAL**
**Instructions for submitting Payer Registration Forms:**

- You must include this page when submitting Payer Registration forms to Emdeon
- Registration forms must be submitted to the address or fax number below
- To obtain forms or additional payer information, visit our website: <http://www.Emdeon.com>.

This Registration form is for a: <input type="checkbox"/> Provider <input type="checkbox"/> Group			
Name*			
Physical Address*			
City, State, Zip*			
Contact Name*			
Contact Phone			
Contact Fax			
Contact Email Address §			
<input type="checkbox"/> NPI ID*	<input type="checkbox"/> Group ID*		
	<input type="checkbox"/> Provider ID*		
<input type="checkbox"/> Tax ID* <input type="checkbox"/> SSN	Site ID*		
Vendor Submitter ID*	Division ID*		
Vendor Name*			
Additional Info			

\* Required Information if applicable.

§ All Approval Notifications will be sent to this address

**Submit Original Payer Registration forms that require original signatures to:**

Emdeon Business Services  
 Attn: Enrollment Dept  
 Donelson Corporate Ctr Bldg 3  
 3055 Lebanon Pike Ste 2000  
 Nashville, TN 37214

**For all other forms:**

**Fax:** (615) 231-4843

**Email:** [batchenrollment@Emdeon.com](mailto:batchenrollment@Emdeon.com)

**To avoid claim rejection, please do not submit electronic claims before receiving [Emdeon](#) Approval Notification.**



# 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.**

	Medicare Provider Number
<i>(Must be the same as Block G) →</i>	
Name of Group, Physician, or Supplier	NPI Number
Address of Group, Physician, or Supplier ( <i>street</i> )	
Address of Group, Physician, 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, 1B/L2, P.O. Box 890011, Camp Hill, PA 17089-0011



COMPLETE ALL FIELDS. TYPE OR PRINT AND MAIL TO:

Highmark Medicare Services Inc. - EDI 1B/L2,  
P.O. Box 890011, Camp Hill, PA 17089-0011

Medicare  
Part B

**ELECTRONIC DATA INTERCHANGE (EDI) SETUP REQUIREMENTS**

<b>A</b> NAME OF GROUP, PHYSICIAN, OR SUPPLIER <i>(Must match the name on file at Medicare for the Provider Number listed in Block G.)</i>			
_____			
<b>B</b> STREET ADDRESS _____			
CITY _____		STATE _____	ZIP CODE _____
<b>C</b> CONTACT PERSON	<b>D</b> TELEPHONE NUMBER	<b>E</b> FAX NUMBER	<b>F</b> INTERNET E-MAIL ADDRESS
<b>G</b> MEDICARE PROVIDER ID # <i>(To Which Checks Are Issued)</i> _____		NPI # _____	
<b>H</b> Please check one: (Requests will be processed as ANSI ASC X12N Version 4010.A1, the HIPAA-compliant format/version.)			
<input type="checkbox"/> Assign this provider a new electronic billing submitter number.			
<input checked="" type="checkbox"/> Add this provider to existing submitter number <u>0926398</u> and PRJ <u>05Y8</u>			
<b>I</b> PLEASE CHECK MODEM PROTOCOL: <input checked="" type="checkbox"/> HAYES/Z-Modem (MCE customers must use this option.) <input type="checkbox"/> MNP			
<b>J</b> COMPLETE THE VENDOR, BILLING SERVICE, AND/OR CLEARINGHOUSE INFORMATION:			
<input type="checkbox"/> MCE (Only check if enrolling for Medicare-issued software.)			
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: <u>Emdeon 800-845-6592</u>			
Street Address, City, State, and Zip: <u>26 Century Blvd. Suite 601, 5th Colonnade, Nashville, TN 37214</u>			

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.**

<b>AUTHORIZED OFFICIAL:</b> Original Signature	Printed Name	Title	Date Signed
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<b>FOR OFFICE USE ONLY:</b> DO NOT WRITE IN THIS SPACE PA _____ SPECIALTY _____ LOGON _____ VERSION _____ TO _____	<b>L PLEASE READ CAREFULLY AND COMPLETE, AS APPROPRIATE</b> <b>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.</b> 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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