

**NEW YORK MEDICARE (EMPIRE) MEDICAL****For Initial Enrollment with this payer:**

- **ONLY SUBMIT THIS FORM IF YOU ARE IN ONE OF THE FOLLOWING COUNTIES:**
 - Brooklyn, Manhattan, Staten Island, Bronx, New York City, Charlotte, Columbia, Delaware, Dutchess, Greene, Kings, Nassau, Orange, Putnam, Richmond, Rockland, Suffolk, Sullivan, Tryon, Ulster, Westchester
 - **APPLICATIONS FROM OTHER REGIONS WILL BE REJECTED**
 - **Verify your county by zip code at:** <http://www.zipinfo.com/search/zipcode.htm>
- 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.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies are accepted.
- 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# 1090)

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.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies are accepted.
- 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# 1090)

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 , 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 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 YORK MEDICARE (EMPIRE) 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 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, County, 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

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



ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

The 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, and
 - 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 Centers for Medicare & Medicaid Services Agrees to:

1. Transmit to the provider an acknowledgment 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 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 _____

Title _____

Address _____

City/State/Zip _____

By _____ Title _____ Date _____

Provider Number (s): _____ Group Number(s): _____

CHECK ONE: New Submitter/Provider (Return Submitter Action Request Form.)

Joining an Existing Submitter ID# 007903