CAHABA GOVERNMENT BENEFIT ADMINISTRATORS,LLC

Medicare

Please FAX Part B forms to: (205)402-9200
For Part B assistance call EDI: (866)582-3253

Fax

To:	Cahaba EDI	**From:**	
Fax:		**Date:**	
		Fax:	
Ref:			

ATTN: Changes to Remittance Advice Notices based on new CMS directives are in effect. Please ensure you follow all instructions on our web site concerning completion of this application, including information related to remit changes.

Be sure that this cover page is used in your fax submission, it is required to be the **FIRST** page you fax in with the application. This will allow accurate and efficient processing of your application. Failure to send this page as instructed will result in your application being returned to you unprocessed.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS,LLC

Medicare Part B

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Electronic Data Interchange (EDI) Application

General Information:

State: ☐ Georgia ☐ Alabama ☐ Tennessee

Reason for Submission:

Additional Options: CMS Directive: Remit change, please read instructions on web site carefully! ☐ Request Electronic Remits

Electronic Remittances Method of Retrieval

I will be sending claims and/or retrieving remits (Select one from dropdown):

List submitter ID:

Provider Information:

Provider Name:

Provider Address:

City: State: Zip Code:

Mailing/Pay-To Address:

Pay-to City: State: Zip Code:

Provider Contact Name: E-Mail Address:

Phone Number: Ext: Fax Number:

Provider Identifiers & Tax ID (EIN) Numbers: (The **Group** PTAN and NPI are required if applicable. For a solo practice, please list the individual PTAN, NPI, and Tax ID)

Group PTAN: Group NPI: Tax ID:

Method of Interchange (Please do not select any boxes under PC-ACE or direct vendor unless you have an existing submitter ID using one of those methods.) (If using an existing ID with a direct vendor the vendor information is required. Select only one method of interchange per application.):

FREE PC-ACE Pro 32 Software

- ☐ Using an existing submitter ID
- ☐ Reactivating your submitter ID

Sending direct to Medicare using software from a vendor or using All-Payer Version of PC-ACE Pro 32

- ☐ Using an existing submitter ID
- ☐ Reactivating your submitter ID

Vendor Name: Phone Number:

Mailing Address:

City: State: Zip Code:

Vendor Contact Name: E-Mail Address:

Sending through a Billing Service/Clearing House (3rd Party)

Billing Service/Clearinghouse Name:

Mailing Address: Phone Number:

City: State: Zip Code:

Clearing House Contact Name: E-Mail Address:

This Agreement notifies Cahaba Government Benefit Administrators®, LLC, of the provider's consent to participate in Electronic Data Interchange (EDI). EDI may include claims and claims attachments, remittances, eligibility/benefits, claim status, and any other electronic information for Centers for Medicare and Medicaid Services (CMS) federal program data (including but not limited to Title XVIII of the Social Security Act (Medicare) and/or Section 1011 of the Medicare Modernization Act) covered under Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets or Section 1011 of the Medicare Modernization Act (MMA) legislation.

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' A/B MACs or CEDI:

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 A/B MACs, DME MACs or CEDI 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 A/B MAC, DME MAC, CEDI, 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 ID) of the provider on each claim electronically transmitted to the A/B MAC, CEDI, 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 A/B MAC, DME MAC, CEDI, 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 A/B MAC, DME MAC or CEDI (in accordance with §1106(a) of Social Security Act (the Act) (See section 40.1.2.2 below for a complete reference to Medicare's security requirements);
14. That it will research and correct claim discrepancies;
15. That it will notify the A/B MAC, CEDI, or other contractor if designated by CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form (See section 40.1.2.2 below for a complete reference to Medicare's security requirements).

B. The Centers for Medicare & Medicaid Services (CMS) agrees to:

1. Transmit to the provider an acknowledgment of claim receipt;
2. Affix the A/B MAC, DME MAC, CEDI 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 A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the A/B MAC, CEDI or from any subsidiary of the A/B MAC, CEDI, other contractor if designated by CMS, or from any company for which the A/B MAC, CEDI has an interest. The A/B MAC, CEDI, 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 A/B MACs, CEDI, 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 sold directly, indirectly, or by arrangement by the A/B MAC, CEDI, or other contractor if designated by CMS;
6. Notify the provider within 2 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 A/B MAC, DME MAC, CEDI, 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 certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with Cahaba Government Benefit Administrators, LLC, on my behalf.

All of the fields below must be completed except for Submitter ID

Provider/Group Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Group PTAN: _____ Group NPI: _____ Submitter ID (if applicable): _____

Authorized Representative Name: _____ Title: _____

Authorized Signature:_____ Date: _____

Print Form

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