

MEDICARE SOUTH CAROLINA PRE-ENROLLMENT INSTRUCTIONS – 00880



HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard Processing time is 20 business days after receipt of forms.
- Approval will be mailed to the provider. You must notify Office Ally before submitting any claims for electronic transmission.

WHERE SHOULD I SEND THE FORMS?

- Mail the original forms to
Palmetto GBA
Medicare SC Part B EDI, AG-420
PO Box 100145
Columbia, SC 29202-3145

WHO CAN SIGN THE FORMS?

- The provider, owner, or other authorized agent may sign the forms.

WHAT FORM SHOULD I DO?

- SC Part B Electronic Data Interchange Application
- Electronic Data Interchange Enrollment Agreement
- Provider Authorization Form

HOW DO I CHECK STATUS?

- Call 866-749-4301 option 4, option 4, & option 1. Ask if you have been linked to Office Ally's Submitter ID SC10002123. Once you are approved you MUST contact Office Ally and inform them of the approval before submitting any claims for electronic transmission.

EDI Application Form Instructions

The purpose of the **EDI Application Form** is to enroll providers, software vendors, clearinghouses and billing services as electronic submitters and recipients of electronic claims data. **It is important that instructions are followed and that all required information is completed. Incomplete forms will be returned to the applicant, thus delaying processing.**

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 completing the form properly. There are two (2) pages to the application form. The first page is required and the second page should be used only if additional providers need to be listed.

Form Field Name	Instructions for Field Completion
Line of Business Information	Indicate the line of business and state for which you will be transmitting. Select all that apply to this request.
Action Requested: Add Provider(s) Change/Update Delete Apply for New Submitter ID	Indicate the action to be taken on the application form. <ul style="list-style-type: none"> • If you need to add additional providers to an existing submitter ID, check Add Provider(s). • If you request to change or update information about the Submitter and/or Provider, check Change/Update and be sure to include your current Submitter ID. • If you request to delete a provider(s), check Delete and be sure to include your submitter ID. • If you are a new applicant, check Apply for New Submitter ID.
Submitter ID	The submitter ID is used by the submitter to communicate with Palmetto GBA electronically. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID if requested. For changes or additions, enter the Submitter ID to which the change/additions should be applied.
Date	Please enter the date the application is completed.
PPTN ID	The PPTN ID is used by the submitter to directly access our Part B claim status inquiry system. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID. For requests to Add Provider(s) or make a Change , please enter your existing PPTN ID.
DDE ID	The DDE User ID is used by the submitter to directly access our Part A claims processing system. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID, if requested. For requests to Add Provider(s) or make a Change , please enter your existing DDE ID.
Submitter Name	Enter the name of the entity (provider, software vendor, billing service or clearinghouse) that will actually be communicating electronically with Palmetto GBA.
Owner Name(s)	Enter the name of the individual(s) who owns the entity listed above.
Type of Submitter	Check the appropriate box.
EDI Contact Person	The name of the submitter's primary EDI contact. This is the person Palmetto GBA will contact if there are questions regarding the application or future questions about their communications.
Phone	The area code and phone number of the Contact Person listed.
FAX	The FAX number for this location.
Address	The mailing address of the submitter.
City, State, Zip	The city, state and zip code of the submitter.

EDI Application Form

This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS) and American National Standard Institute (ANSI). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

Form Field Name	Instructions for Field Completion
Submitter E-mail Address	The e-mail address of the contact person listed. Note: This will be the primary method of communication. This e-mail address will also receive EDI Tracking Numbers used to monitor the processing status of your EDI forms.
Claim Submission Mode of Communication	There are four available modes of communication modes that can be used for claim submission. Check only one . <ul style="list-style-type: none"> • GPNet: Asynchronous communication with the Gateway • Connect Direct – NDM: Network Data Mover • Dial-up FTP: File transfer protocol transmission via GPNet – not Internet. • Leased FTP: File transfer protocol transmission via the Internet or Network-based connection.
Report / Electronic Remittance Retrieval Mode of Communication	Check only one mode of communication that will be used. <ul style="list-style-type: none"> • GPNet Asynchronous should be checked for asynchronous communication with Palmetto GBA’s GPNet. • CONNECT:Direct (NDM) should be checked for report retrieval via GPNet • Dial-up FTP should be checked for file transfer protocol report retrieval via GPNet. • Leased FTP: File transfer protocol transmission via the Internet or Network-based connection.
Report Response Format	Check the format in which you will receive GPNet Claims Acceptance Responses.
Data Compression	To receive files compressed for faster transmission, indicate which data compression utility you support.
Name of Software Vendor	Indicate the name of the software vendor you are using, if applicable.
Vendor ID	Include Vendor ID number if known.
Name of Online Inquiry Services Connectivity Vendor	If applicable Indicate the name of the Online Inquiry Services Connectivity Vendor you are using or plan to use for access to Direct Data Entry (DDE) or Professional Provider Telecommunications Network (PPTN).
Providers For Whom Submitter Will Be Communicating Electronically:	
Provider Name	List each provider whose bills will be submitted by the submitter named above. (If additional providers need to be listed, indicate each one separately on the <i>Multiple Providers List</i> form.) This name must match the name submitted on the CMS 855 Medicare Enrollment Application.
Provider E-mail address	Indicate the e-mail address for the provider listed above. This e-mail address will be the primary source of communications regarding approval of changes to their EDI options.
Provider Number	Indicate the Medicare Provider Number for each provider listed.
NPI	Include the National Provider Identifier (NPI).
Enrollment Form Attached: Y/N	Indicate “Y” for Yes or “N” for No. A properly executed 3-page EDI Enrollment Agreement must be attached for <i>each</i> provider listed. Palmetto GBA will not activate a submitter ID for any provider without a properly executed enrollment form.
Provider Authorization Form Attached: Y/N	Indicate “Y” for Yes or “N” for No. A provider authorization form is required to authorize a clearinghouse and/or billing service as an electronic submitter and recipient of electronic claims data.
Submit Claims	Check this box if the application is for the submitter to submit claims electronically for this provider.
Receive Reports	Check this box if the submitter wants to receive response reports electronically for the provider indicated.
Receive Electronic Remittances	Check this box if the submitter wants to receive Electronic Remittances for the provider indicated. Provider must be submitting claims electronically to receive Electronic Remittances.

EDI Application Form

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Form Field Name	Instructions for Field Completion
Online Inquiry	Check this box if the submitter currently uses or plans to use the Online Inquiry Services (DDE or PPTN).

Once you have completed the application form, please retain a copy for your records and mail the original to the address listed below. Your Submitter ID and software (if applicable) will be processed within 20 business days of receipt of completed forms. Submit completed form to:

Palmetto GBA
EDI Operations, AG-420
PO Box 100145
Columbia SC 29202-3145

Palmetto GBA <small>PARTNERS IN EXCELLENCE</small>		EDI Application	
Line of Business Information: <input type="checkbox"/> SC Part A <input type="checkbox"/> SC Part B <input type="checkbox"/> NC Part A <input type="checkbox"/> RHHI			
Action Requested: <input type="checkbox"/> Add Provider(s) <input type="checkbox"/> Change / Update <input type="checkbox"/> Delete <input type="checkbox"/> Apply for New Submitter ID			
Submitter ID (if available): _____		Date: _____	
PPTN ID: _____		DDE ID: _____	
Submitter Name: _____			
Owner Name: _____			
Type of Submitter: <input type="checkbox"/> Software Vendor <input type="checkbox"/> Billing Service <input type="checkbox"/> Provider <input type="checkbox"/> Clearinghouse			
EDI Contact Person: _____			
Phone: _____		Fax: _____	
Address: _____ _____			
City: _____		State: _____	ZIP: _____
Submitter E-mail Address: _____			
Note: E-mail will be the primary method of communication.			
Claim Submission Mode of Communication:		<input type="checkbox"/> GPNet Asynchronous <input type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Dial-up FTP <input type="checkbox"/> Leased FTP
Report / Electronic Remittance Retrieval Mode of Communication:		<input type="checkbox"/> GPNet Asynchronous <input type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Dial-up FTP <input type="checkbox"/> Leased FTP
Report Response Format:		<input type="checkbox"/> File	<input type="checkbox"/> Report
Data Compression:		<input type="checkbox"/> Uncompressed (GPNet Default) <input type="checkbox"/> PKZIP	<input type="checkbox"/> UNIX-Compress
Name of Software Vendor: _____		Vendor Security ID: _____	
Online Inquiry Connectivity Vendor: <input type="checkbox"/> IVANS <input type="checkbox"/> VisionShare <input type="checkbox"/> Other:			

Providers for Whom Submitter Will Be Transmitting

Provider Name: _____			
Provider E-mail Address: _____			
Provider Number: _____		NPI: _____	
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No		Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports	<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Submit completed form to: **Palmetto GBA**
 EDI Operations, AG-420
 PO Box 100145
 Columbia SC 29202-3145

Please retain a copy for your records.
 You must submit a completed EDI Application Form when submitting additional EDI forms.



EDI Application

Multiple Providers List

Date: _____

PROVIDERS FOR WHOM SUBMITTER WILL BE TRANSMITTING:

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Submit completed form to: **Palmetto GBA**
 EDI Operations, AG-420
 PO Box 100145
 Columbia SC 29202-3145

Please retain a copy for your records.
 You must submit a completed EDI Application Form when submitting additional EDI forms.

EDI Enrollment (Agreement) Form and Instructions

The EDI Enrollment Form (commonly referred to as the EDI Agreement) should be submitted when enrolling for electronic billing. It should be reviewed and signed **only** by the providers to ensure each provider is knowledgeable of the enrollment request and the associated requirements.

Providers that have contracted with a third party (clearinghouse/network service vendor or a billing agent) are required to have an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to the 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 letter of:

- Any changes in their billing agent or clearinghouse.
- The effective date of which the provider will discontinue using a specific billing agent or clearinghouse.
- If the provider wants to begin to use additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouse begins to use alternate software, the clearinghouse is 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.

General Instructions:

- Please ensure that you include your **Medicare Provider Number** and **National Provider Identifier [NPI]** where requested on the EDI Enrollment Form.
- If the submitter will be submitting for multiple providers, this form must be completed by *each* provider whose claim data will be submitted.
- The entire form must be read carefully, dated with day, month and year.
- The name of the provider must be printed in the space provided, an authorized officer's name (printed), authorized officer's title and signature.
- When completed, the properly executed **3-page EDI Enrollment Form** must be returned *with* the **EDI Application** form to the following address:

Palmetto GBA
EDI Operations, AG-420
PO Box 100145
Columbia, SC 29202-3145

Note: If the submitter will be an entity other than the provider, the submitter must complete the EDI Application form and the provider(s) must complete the EDI Enrollment Form(s). The EDI Application form must be returned with the EDI Enrollment Form enclosed for each applicable provider.

IMPORTANT NOTE:

The address shown on the EDI Enrollment Form must match the address that was submitted to our Provider Enrollment Department when enrolling for a provider number. If the address on the completed EDI Enrollment Form does not match, your entire EDI Enrollment Packet will be returned.

The National Provider Identifier (NPI) must be printed in the space provided on the EDI Enrollment Form. If this information is missing, the EDI Enrollment Form will not be processed.

EDI Enrollment Agreement

This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS) and American National Standard Institute (ANSI). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

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 2 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 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 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): _____

Complete ALL fields above and mail entire agreement (three pages) with **original** signature and **with** a copy of the **EDI Application form** to:

Palmetto GBA
 EDI Operations, AG-420
 PO Box 100145
 Columbia SC 29202-3145

Provider Authorization Form Instructions

The purpose of the notice is to authorize a clearinghouse and/or billing service as an electronic submitter and recipient of electronic claims data. It is important that instructions are followed and that all required information is completed. Incomplete forms will be returned to the applicant, thus delaying processing. Please retain a copy of this complete notice for your records.

Please retain a copy of this completed form for your records.


You must submit a completed EDI Application Form when submitting this form. The Provider Authorization form must be completed and signed by the Provider.

The field descriptions listed below will aid in completing the notice properly.

Form Field Name	Instructions for Field Completion
Line of Business Information	Indicate the line of business and state for which you will be transmitting. Select all that apply to this request.
Action Requested	Indicate the type of service(s) you are authorizing the Submitter to access. Check all that apply.
Provider Name	List the provider name for which this Provider Authorization Form is being completed. This name must match the name submitted on the CMS 855 Medicare Enrollment Application.
Provider E-mail Address	The e-mail address of the provider to receive EDI notifications.
Provider Number	List the provider PTAN whose Medicare claims, electronic remittances, response reports or PPTN/DDE will be accessed by the submitter listed on the EDI Application. A separate Provider Authorization Form is required for each PTAN.
NPI	Indicate the National Provider Identifier (NPI).
Name/Title	The name and title of the person Palmetto GBA will contact if there are questions regarding this Authorization Form.
Address	The mailing and/or the physical address of the provider. (Only one valid address has to be submitted.)
City, State, Zip	The city, state and zip code of the provider.
Phone Number	The area code and phone number of the Contact Person listed.
Submitter's Name	The name of the Submitter you are authorizing for the above services.
Signature	The signature of the listed provider's authorized contact.
Date	The date the form was signed.

Provider Authorization Form

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 <h2 style="margin: 0; display: inline-block; margin-left: 20px;">Provider Authorization Form</h2>
This form must be completed and signed by the Provider ONLY.
Line of Business Information: <input type="checkbox"/> SC Part A <input type="checkbox"/> SC Part B <input type="checkbox"/> NC Part A <input type="checkbox"/> RHHI
Action Requested: <input type="checkbox"/> Electronic Claims Submissions <input type="checkbox"/> Electronic Remittance <input type="checkbox"/> Electronic Response Reports <input type="checkbox"/> Online Inquiry Services (PPTN or DDE)
Provider for whom Submitter will be granted access
Provider Name: _____
Provider E-mail Address: _____
Provider Number: _____ NPI: _____
Name: _____
Title: _____
Address: _____ _____
City: _____ State: _____ ZIP: _____
Phone: _____
Submitter Name: _____
<p>I hereby authorize the above submitter to receive the items notated above on my behalf. I understand that these items contain payment information concerning my processed Medicare claims. I am authorized to endorse this access on behalf of my company, and I acknowledge that is my responsibility to notify Palmetto EDI in writing if I wish to revoke this authorization.</p>
Signature: _____ Date: _____

Please complete and return this form, with the EDI Application Form, to:

Palmetto GBA
 EDI Operations, AG-420
 PO Box 100145
 Columbia SC 29202-3145