51101

Hypertext Transfer Protocol Secure (HTTPS) Council for Affordable Quality Healthcare (CAQH) Committee on Operating Rules (CORE)-Compliant Connection For Electronic Data Interchange (EDI) Enrollment

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

FIRST COAST SERVICE OPTIONS

All fields marked with * are required and must be completed. Reference Materials are available on the last page of this document.

General Information

R5-25

*Contract/State(required):Select one from dropdown	*Line of Business:Select one from dropdown

Provider Information *(Must match the name for the Group/Billing Provider on file with Medicare as reported on the CMS-855 Enrollment form)*

*Provider name:	*Contact name:
*Contact telephone number:	Contact fax number:
*Street address:	*City:
*State/Province:	*Zip code/Postal code:
*Email address for listserv and enrollment response:	

Provider Identification *The PTAN/NPI reported below should NOT be the group MEMBER PTAN/NPI. PTANs may also be known as a CMS Certification Number. For Affiliated PTANs or NPIs, attach a signed list on company letterhead, if needed.*

*Provider Transaction Access Number (PTAN):	*National Provider Identifier (NPI):	*Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)

HTTPS CAQH CORE-Compliant Connection for EDI

Customers utilizing the HTTPS CAQH CORE-Compliant Connection for EDI must have the following in order to connect:

- Purchase an X.509 certificate which must be recertified at intervals defined by the certificate authority (CA).
- Contract with an approved Network Service Vendor (NSV) to send the valid X.509 certificate via Secure File Transfer Protocol (SFTP).
- Develop or obtain a CAQH CORE connectivity Rule 270-compliant client software.

☐ **By checking this box, I acknowledge that I have read the above prerequisites for connecting via the HTTPS CAQH CORE-compliant connection.**

Type of Request

Reason for submission: Select one

*Transaction selection. Choose only one:	
☐	Create ANSI ASC X12N 276 claim status files and receive ANSI ASC X12N 277 claim status files
☐	Retrieve ANSI ASC X12N 835 remittance files
☐	Create ANSI ASC X12N 276 claim status files and receive ANSI ASC X12N 277 claim status files and retrieve ANSI ASC X12N 835 remittance files

Additional Information *(Optional)*

Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier)

Select one

Agreement

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

The Provider Agrees:

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 Medicare beneficiary identifier, 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 identifier) 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 the Social Security Act) (the Act).
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.

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

1. Transmit to the provider an acknowledgement 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's 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 contractor 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.

NOTICE:
Federal law and applicable regulation and guidance, including IOM Pub. 100-04, Chapter 24, Section 30.2, 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/Section 1011 claims or any other EDI transactions are submitted to CMS or the CMS contractor. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate, except as noted in applicable regulation and guidance, including IOM Pub. 100-04, Chapter 24, Section 30.2. 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.

If Providers elect to submit/receive transactions electronically using a third party such as a billing agent or a clearinghouse, the A/B MACs or CEDI must notify these providers that they are required to have an agreement signed by that third party. The third party must 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.)

Attestation

Any provider who submits Medicare claims electronically to CMS or its contractors remains responsible for those claims as those responsibilities are outlined on the EDI Enrollment. 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 used to facilitate 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 it chooses to use to submit the claim.

Prior to signing this agreement, please carefully review the technical requirements for electronic billing in our companion guides: medicare.fcso.com/EDI_resources/

New EDI submitters must connect to First Coast Service Options within 90 days of receiving the logon ID by using the Secure File Transfer Protocol (SFTP) software provided by your Network Service Vendor.

I understand that any individual who knowingly and willfully makes or causes to be made any false claim or false statement of false representation of a material fact in any application to the federal government for benefits or payment with respect to the Medicare program may be subject to civil and/or criminal enforcement action which may result in fines, penalties, damages and/or imprisonment.

*Authorized/Delegated Official Signature Requirements

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 First Coast Service Options on my behalf.

By signing below, the provider confirms they have read and agree to the Agreement, the Attestation, and the above signature requirements.

***The Authorized Official signing this form should be an AUTHORIZED OR DELEGATED OFFICIAL that was listed on the Medicare Enrollment Application (CMS-855).**

*Required Signature	
*Written Signature of Person Submitting Enrollment (add after you print the form)	*Date
*Printed Name of Person Submitting Enrollment	*Printed Title of Person Submitting Enrollment:

Complete form, print, sign, date, and email (recommended), mail, OR fax all pages to:

Email: MedicareEDI@fcso.com

Fax: (904) 361-0470

Post: First Coast Medicare EDI, P.O. Box 3703, Mechanicsburg, PA 17055-1861

Allow 10 business days for processing. Please do not send duplicate forms.

Print Form Clear Form

SPOT

The Secure Provider Online Tool (SPOT) is a free web-based application that provides access to an abundance of Medicare data and lets users view the status of claims and the benefits/eligibility data of beneficiaries. Users can also easily look up a Medicare Beneficiary Identifier (MBI), retrieve documentation, and electronically submit forms. Finally, users can search payment history data and request data reports, and new SPOT features are always being added. For additional information, visit https://medicare.fcso.com/Landing/0399472.asp.