



51110



## EDI SPOT Enrollment Form for Third-Party Provider Organizations



This option is for Billing Services or Clearinghouses that wish to have access to Medicare data via the internet. Please complete this form for enrollment to SPOT (Secure Provider Online Tool), First Coast Service Options' internet portal. All fields marked with \* are required and must be completed or the request will be rejected.

<b>*Third-Party Information</b>		R01-22
*Legal business name:	*Nine-digit Tax ID #:	
*Street address:	*City:	
*State:	*Zip Code:	
*Website Address:	Fax Number:	

<b>*Third-Party Contact Information</b>		
*Technical Contact Name/Department:	*Telephone:	*Email Address:
*Marketing Contact:	*Telephone:	*Email Address:

**Note:** An email may be sent to the Technical Contact's email address when the form is processed. The email address of the Technical Contact may be added to the EDI mail list to receive important email publications from First Coast Service Options EDI. The Technical Contact email may be used for enrollment processing responses for any forms needing returned. The company name, marketing contact phone number, and marketing contact email address will be used for publication on the Approved Vendor List on the First Coast Service Options website.

**\* Approved vendor's list on EDI's website:**

### Approver Designation

This form is for third-party provider agents, e.g., billing services and clearinghouses, to designate who the approver and backup approver will be. Approvers designated by their organization must register in IDM (Identity Management System) once they receive approval from First Coast. Go here for more on how to register in DM -- <https://medicare.fcso.com/faqs/answers/241528.asp>. **Note:** Those requesting end user access to SPOT are not required to complete this form.

**The designated members below will approve end-users who request access. At least one approver is required.**

<b>* Approver Designation Contact Information</b>		
* Approver First Name:	* Approver Last Name:	* Approver Email Address:
Backup Approver First Name:	Backup Approver Last Name:	Backup Approver Email Address:



## Type of Request

**\*Please choose your request type. Click only one:**

	Assign a new electronic submitter ID for 837 claim submission via SPOT
	I am a <input type="checkbox"/> Billing Service or <input type="checkbox"/> Clearinghouse (If nothing or both are selected, submitter will be setup as a billing service.)
	I am currently using submitter ID: <input type="checkbox"/> ERA Change Only <input type="checkbox"/> Other Feature Change or Contract Only - indicate in Features/Contracts

## Features/Contracts

**\*What features/contracts do you support? Click all that apply:**

	<input type="checkbox"/> Create ANSI ASC X12N 837 claim
	<input type="checkbox"/> Create ANSI ASC X12N 276 claim status files and receive ANSI ASC X12N 277 claim status files.
	Provide services to the following contracts - check only those that currently apply or you would like to add: Part A: <input type="checkbox"/> FL <input type="checkbox"/> PR <input type="checkbox"/> USVI Part B: <input type="checkbox"/> FL <input type="checkbox"/> PR <input type="checkbox"/> USVI
	<input type="checkbox"/> Enroll for PC-ACE

**When selecting to enroll in PC-ACE, you are agreeing to the software terms listed below.**

- First Coast Service Options is authorized to distribute PC-ACE/PRINTLINK/ETRA (herein referred to as the "Program") to authorized users. PC-ACE and PRINTLINK software programs are copyrights of ABILITY. The Program is distributed for the purpose of creating electronic Medicare claim files only. Any use not authorized herein is strictly prohibited, including but not limited to, making copies of any part of the Program, reselling, or transferring copies to any party, or creating any modified or derivative work.
- The Program is provided "as is" without warranty of any kind, either expressed or implied, including but not limited to the implied warranties of merchantability or fitness for particular purpose.
- In no event will First Coast Service Options be liable for any loss or damage, including but not limited to incidental or consequential damages, arising out of the use or inability to use the Program even if First Coast Service Options has been advised of the possibility of such damages, or for any claim by any other party.
- The authorized user will upgrade this Program within 90 days of upgrade availability. This is a CMS requirement.
- The authorized user will provide the necessary office space, all electrical and telephone connections, hardware, telecommunication software and equipment that adhere to the technical requirements located on our [website](#).
- Internet download is the preferred method of software installation. Internet download instructions will be provided upon processing of this enrollment. There is no fee for software installation via Internet download. If you choose to receive the program in a CD-ROM format, contact Medicare EDI at 888-670-0940. Do not send payment with this request.

By enrolling, users agree to use an approved software vendor of [First Coast's 5010 approved vendor](#) to create the claim file sent through the SPOT claim submission feature.

**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 third party agent. The responsibilities and obligations contained in this document will remain in effect as long as electronic data interchange is being conducted with an A/B MAC, DME MAC or CEDI. Either party may terminate this arrangement by giving the other party (30) days notice of its intent to terminate. In the event that the notice is mailed, 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.

**Signature:** The signatory hereto represents and warrants that he/she is duly authorized to sign, execute, and deliver this Agreement on behalf of the party it represents for the Medicare Program 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 on my behalf.

## \*Required Signatures

*Authorized Official Signature:	*Date:
*Name of Authorized Official (Print):	*Title of Authorized Official:

Once you complete the form and sign it, click the Submit button below to email the form to First Coast Service Options' SPOT help desk, or you can fax or mail a printed version of the completed form using the information below.

**Email:** MedicareEDI@fcso.com | **Fax:** (904) 361-0470 | **Mail:** First Coast Medicare EDI, P.O. Box 3703 Mechanicsburg, PA 17055-1861