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:

Please ensure 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.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS,LLC

Medicare Part B

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Electronic Data Interchange (EDI) Application

General Information:

State: ☐ Georgia ☐ Alabama ☐ Mississippi ☐ Tennessee

I am requesting to (Select one from dropdown): _____

Additional Options: ☐ Request Electronic Remits ☐ PPTN Access
☐ Perform 276/277 (Batch Claim Status)

I will be sending my claims and retrieving remits (Select one from dropdown): _____

List submitter ID _____

Provider Information:

Group, Provider, or Facility Name: _____

Mailing/Pay-To Address: _____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ E-Mail Address: _____

Phone Number: _____ Fax Number: _____

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

Group PTAN: _____ Group NPI: _____ EIN: _____

Method of Interchange:

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:

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:

Contact Name: E-Mail Address:

Professional Provider Telecommunications Network (PPTN): (Please indicate connectivity vendor below)

○ IVANs ○ Vision Share Other:

System Access Requests, please list complete names of all users you are requesting access for (Requests to add users to multiple PTAN's will have to come on separate applications):

First Name	Middle Name	Last Name	EDC ID	PPTN ID	PIN	Request

Authorized Signature:_____

Printed Name

Title

Date

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:

1. That it will establish and maintain procedures and controls so that information concerning Medicare and/or Section 1011 beneficiaries, or any information obtained from CMS or its contractors, shall not be used by agents, officers, or employees of a business associate except as provided by the contractor (in accordance with §1106(a) of the Social Security Act (the Act));
2. That it will use sufficient security procedures (including compliance with all provisions of the HIPAA security regulations) to ensure that all electronic transmissions are authorized and protect all beneficiary-specific data from improper access;
3. That it will notify the contractor or CMS within two business days if any transmitted data are received in an unintelligible or garbled form.
4. The provider agrees to the following provisions for submitting and retrieving/receiving Medicare and/or Section 1011 information electronically to/from CMS or CMS contractors:

a) That it will be responsible for all Medicare and/or Section 1011 transactions submitted to CMS by the provider, its employees, or its business associates;

b) That it will not disclose any information concerning a Medicare and/or Section 1011 beneficiary to any other person or organization, except CMS and/or its contractors, without the express written permission of the Medicare/Section 1011 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 and/or Section 1011, or as required by State or Federal law; That it will submit claims only on behalf of those Medicare and/or Section 1011 beneficiaries who have given their written permission to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file;

c) That it will submit claims only on behalf of those Medicare and/or Section 1011 beneficiaries who have given their written permission to do so, and to certify that required beneficiary signatures, or legally authorized signatures on behalf of beneficiaries, are on file;

d) That it will submit/request electronic transactions on only those beneficiaries with whom the provider has a professional relationship;

e) That the CMS-assigned unique identifier number (submitter identifier) constitutes the provider's legal electronic signature and when used for claims submission, it constitutes an assurance by the provider that services were performed as billed;

f) That it will ensure that every electronic claim can be readily associated and identified with an original source document. Each source document must reflect the following information (except if not required for Section 1011):

- 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 CMS 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 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 or Section 1011 primary payment have been developed for other insurance involvement and that Medicare/Section 1011 is indeed 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 six years, three months after the bill is paid, or, for Section 1011 beneficiaries, in accordance with the Section 1011 Final Policy Notice;
9. That it will research and correct claim discrepancies;
10. That it will affix the CMS-assigned unique identifier number (submitter identifier) of the provider on each claim electronically transmitted to the CMS contractor;
11. 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 or Section 1011 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;
12. That if it chooses to participate in electronic remittance transactions it will notify the CMS contractor of any changes in third-party services that it has authorized to access this information on their behalf via the EDI Enrollment form;
13. That if it chooses to use a Network Service vendor for eligibility verification transactions it will notify the CMS contractor of any changes in third-party service arrangements via the EDI Enrollment form;

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

1. Transmit to the provider an acknowledgment of claim receipt;
2. Affix the CMS contractor 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 CMS contractor may require the provider to purchase any or all electronic services from the CMS contractor or from any subsidiary of the CMS contractor or from any company for which the CMS contractor has an interest. The carrier or FI 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 CMS contractor sells directly, or indirectly, or by arrangement;
6. Notify the provider within two 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/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. 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.*

Signature: **(By signing this document you are stating that you are authorized to sign on behalf of the indicated party and have read and agree to the foregoing provisions and acknowledge same)**

Provider's Name _____ Title _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

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

Printed Name _____ Signature:_____

Print Form