



WHEN EXPERIENCE COUNTS AND QUALITY MATTERS

## Electronic Data Interchange -- Fax coversheet (REQUIRED)

This fax contains sensitive information including PHI (Personal Health Information) or PII (Personally Identifiable Information).

Date: \_\_\_\_\_

Number of pages including cover: \_\_\_\_\_

To: Medicare EDI

Phone: (888) 670-0940

Fax: (904) 361-0430

From: \_\_\_\_\_

Email: \_\_\_\_\_  
(Required if changing Authorized Signer)

Phone: \_\_\_\_\_  
(Required if changing Authorized Signer)

Fax: \_\_\_\_\_  
(Required if changing Authorized Signer)

**Please indicate which type of information you are faxing. If the proper box is not checked, it may delay processing.**

DDE (Direct Data Entry) User ID Compliance Statement and Fax Coversheet (3 pages)

DDE Change of Authorized Signer **ONLY** - Fax Coversheet only (1 page)

Facility Name (Required): \_\_\_\_\_

Facility OSCAR number (Required): \_\_\_\_\_

Typed Name of Authorized Signer (Required): \_\_\_\_\_

Signature of Authorized Signer (Required): \_\_\_\_\_

### PRIVILEGED AND CONFIDENTIAL

The information contained in this document may be confidential and is intended solely for the use of the individual or entity to whom it is addressed. This document may also contain material that is privileged or protected from disclosure under applicable law. If you are not the intended recipient or the individual responsible for delivery to the intended recipient, please (1) be advised that any use, dissemination, forwarding, or copying of this document IS STRICTLY PROHIBITED; and (2) notify sender immediately by telephone and confirm destruction of the document. Thank you.

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First Coast Service Options Inc.

Revised: 12/23/14

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**DDE USER ID COMPLIANCE STATEMENT**  
**MEDICARE PART A - DDE ACCESS REQUEST FORM**  
**Instructions**

Forms that are not legible or filled out correctly will be returned. Process time is 10 business days from the date a correct form is received.

**Section 1: Facility Information**

- List the Facility name Address, City, State and ZIP Code for the Authorized Signer. This information must be where the Authorized Signer is located.

**Section 2: Type of Request**

- New User ID: Select this option if the user has never been assigned a User ID or was previously assigned a User ID but does not remember the User ID.
- Reactivate ID: Select this option to reactivate a User ID that has been deactivated due to non- usage. The ID can only be reactivated for the user the ID was originally assigned to.
- Terminate ID: Select this option to terminate User IDs that are no longer needed.
- Add PTAN to ID: Select this option to add additional PTANs to an existing User ID issued by First Coast Medicare
- Change Access to Full: Select this option to change a user's access to full.
- Add PR Workload: Select this option to add Puerto Rico workload to a User ID created by another Carrier.
- Add FL Workload: Select this option to add the Florida workload to a User ID created by another Carrier.
- Change Access to Inquiry: Select this option to change a user's access from "Full" to "Inquiry".
- Remove PTAN: Select this option to remove PTANs that are no longer needed but the ID is still needed to access other PTANs.
- **Section 3: User Information** - Only one user request per form.
  - User Name: Enter the name of the person who will be accessing the system or is being terminated.
  - Signature: Signature of person whose name appears in the User Name field.
  - User ID: Enter the existing User ID.
  - PIN: Enter a 4-digit numeric PIN (typically the last 4 digits of the users Social Security or Employee Number) to be used for password resets.
  - Type of Access: Select one of the following:
    - Full access: Provides the ability to edit claims and access CWF.
    - Inquiry access: Provides the ability to view claims only and access to the Common Working File (CWF).
    - Eligibility Only: Provides the ability to access ELGA or HIQA only.

**Section 4: Is the User located outside the United States?**

- Select "No" if the user is located inside the United States.
- Select "Yes" if the user is located outside of the United States.
  - If you select "Yes" you must contact CMS to obtain an authorization letter and attach the letter before requesting access for the user.

**Section 5: Medicare Part A Provider Number**

- List the Provider number (also referred to as PTAN, Oscar, or Medicare number) the user needs access to.

**Section 6: Authorized Signer**

- The Authorized Signer is the person identified by the facility that has the authority to request access to the DDE System. The Authorized Signer is responsible for ensuring the user understands that their ID and password cannot be shared with another user, terminates IDs immediately when the ID is no longer needed, verifies the user does not already have a User ID before submitting a request for a new User ID, keeps track of all users and their assigned User ID, ensures that User IDs are not being requested for users located outside of the United States unless there is a signed authorization letter from CMS, and completes the annual DDE User ID Recertification to recertify the user's access.



**MEDICARE**  
Electronic Data Interchange

**FIRST COAST SERVICE OPTIONS, INC.  
MEDICARE PART A COMPUTER SECURITY  
ADMINISTRATION DDE  
USER ID COMPLIANCE STATEMENT**

This DDE User ID Compliance Statement, entered into this \_\_\_\_ day of \_\_\_\_\_, \_\_\_\_ is by and between First Coast Service Options, Inc. (hereinafter "First Coast"), located at 532 Riverside Avenue, Jacksonville, Florida 32202 and \_\_\_\_\_ (hereinafter "we" or "Provider") located at \_\_\_\_\_.

We, the undersigned, hereby request receipt of the DDE USER ID, which will be used to gain access to the First Coast, Medicare Part A network to perform Medicare Part A Direct Data Entry functions.

We agree to:

1. Be responsible for all activities logged under this DDE USER ID.
2. **Not share or exchange this DDE USER ID or password.**
3. Report to Computer Security Administration any suspected misuse of the DDE USER ID.
4. Use the system to perform tasks only for First Coast Service Options, Inc. business.
5. Follow established corporate policy as described in the Corporate Computer Information Security Policy.

Non-Compliance with the above is considered to be unacceptable behavior, which will be cause for First Coast to revoke access to the Direct Data Entry (DDE) system.

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**In accordance with First Coast Corporate Computer Security Policy, your DDE USER ID is not to be used by anyone other than yourself. Also, your password is not to be revealed to anyone, including Supervisors and Managers. This DDE USER ID will remain with you as long as you are employed by the aforementioned facility as First Coast Computer Security monitors all of your activity. If at any time you believe that someone has used your DDE USER ID, or someone asks you to reveal your password, contact Medicare Part A, DDE Support, at (888) 670-0940, option 3.**

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The Fax coversheet and both pages of the completed DDE User ID Compliance Statement form should be printed, signed, dated, and returned. Only the Fax coversheet is required to change the Authorized Signer.

**Section 1: Facility Information (All fields are required.):**

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**Section 2: Type of Request (Must select one.):**

New User ID  Reactivate ID  Terminate ID  Add PTAN to ID  Change Access to Full   
Add Puerto Rico Workload  Add Florida Workload  Change Access to Inquiry  Remove PTAN

**Section 3: User Information (Only one user per application.):**

User Name (First, Middle Initial, Last): **(Required.)** \_\_\_\_\_

Signature: **(Required unless terminating User ID.)** \_\_\_\_\_

User ID: **(Required unless requesting new User ID.)** \_\_\_\_\_

Pin: **(Must be 4 numeric. Required unless terminating User ID.)** \_\_\_\_\_

Type of Access: **(Must select one.)** Full  Inquiry  Eligibility Only

**Section 4: Is the User located outside the United States? (Must select one.):**

No  Yes  (If yes, you must attach the authorization letter from CMS.)

**Section 5: Medicare Part A Provider OSCAR number (s) (Minimum of one OSCAR is Required.):**

\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

If additional access is needed, please indicate OSCAR numbers on a separate page.

**Section 6: Authorized Signer (All fields are required. If the Authorized Signer's name is listed in Section 3, please obtain the signature of another Authorized Signer.):**

By signing below, you acknowledge that you are the Authorized Signer for the user listed in Section 3. If this request is for a new User ID, you have verified that the user does not already have a User ID with First Coast. The user is aware that the User ID and password cannot be shared with another user. That access will not be requested for a user who works for an outsourcing company located outside of the United States without a signed authorization letter from CMS.

Authorized Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**Section 7: Submitting Form:**

All forms are completed in the order in which they are received. The Authorized Signer will receive an email if the form cannot be processed or a confirmation letter and instructions to setup/reset the Users password (as appropriate). Please allow 10 business days from the date of receipt for the application to be processed. The Fax coversheet and both pages of the completed DDE User ID Compliance Statement form should be printed, signed, dated, and returned. If you have any questions, contact the DDE Support at 888-670-0940. Revised: