

# Railroad Medicare PRE-ENROLLMENT INSTRUCTIONS – MR018



## HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is approximately 4 weeks

## WHERE SHOULD I SEND THE FORMS?

- Mail the forms to Office Ally  
PO Box 872020  
Vancouver, WA 98687

## WHO CAN SIGN THE FORMS?

- Forms should be signed by the provider or person with signature authorization

## WHAT FORMS SHOULD BE COMPLETED?

- Complete the following two forms if the provider has never submitted electronically to Railroad Medicare
  - Railroad Medicare Information Form
  - Railroad Medicare EDI Enrollment Agreement form

### **BOTH FORMS MUST BE COMPLETED**

- Complete the following form if the provider has submitted electronically to Railroad Medicare and is just transferring to Office Ally
  - Railroad Medicare Change Form

## HOW DO I CHECK STATUS?


- To check status, call Medicare at 866-749-4301 and ask if provider number has been linked to Office Ally, submitter number RR3426
- If it has been linked, you MUST notify Office Ally prior to submitting claims

## WHAT PROVIDER NUMBER DO I USE?

- Forms must contain a valid Railroad Medicare Provider Number
- Can I use my tax ID, NPI, or State Medicare Number instead?
  - No – you may only use a valid Railroad Provider number. If you don't know your Railroad Provider number, call Railroad at 877-288-7600 or 866-749-4301
  - If your Railroad number is pending, you must wait until it is assigned before completing this form

## I'M A GROUP – DO I LIST EACH DOCTOR'S PROVIDER NUMBER?

- No, if you have a group number, list only the group name and group number on your application
- If you have multiple group numbers, you must complete an entire application

 <b>Railroad Medicare EDI Information Form</b>	
Mail Completed Form To: Railroad Medicare EDI PO Box 10066 Augusta, GA 30999	<input type="checkbox"/> New Request <input type="checkbox"/> Update Info Current Date: _____
<b>Check One:</b> <input type="checkbox"/> Vendor <input type="checkbox"/> Billing Service <input type="checkbox"/> Submitter <input type="checkbox"/> Clearinghouse	
<b>PART A – PROVIDER DATA</b>	
Name:	Submitter ID (If assigned):
Address:	
City, State, Zip:	
Contact:	E-mail:
Phone: (    )      Ext:	Fax: (    )
Railroad Medicare Provider Number:	
National Provider Identifier (NPI):	
<b>Check One:</b> <input type="checkbox"/> Provider is Submitter (Provider submits claims directly from their office. Fill out Part B below.) <input type="checkbox"/> Provider is with Billing Service/Clearinghouse (Fill out Part C below.)	
Request Electronic Remittances (ANSI 835 v4010A1): <input type="checkbox"/> No <input type="checkbox"/> Yes (must complete Addendum to Electronic Remittance Enrollment Form for Billing Services and Clearinghouses form)	
<b>PART B – EDI SOFTWARE VENDOR DATA</b>	
Check here if you will be using PC-ACE Pro32 Software provided by Palmetto GBA: <input type="checkbox"/>	
Vendor Name:	
Contact:	Phone: (    )      Ext:      Fax: (    )
Address:	
City, State, Zip:	
Vendor ID:	E-mail:
Response Format: <input type="checkbox"/> File <input type="checkbox"/> Report Format	Mode: <input type="checkbox"/> ASYNCH <input type="checkbox"/> CONNECT:Direct <input type="checkbox"/> FTP
Data Compression: <input type="checkbox"/> PKZIP (Version 2.04g or compatible)	<input type="checkbox"/> UNIX <input type="checkbox"/> None
<b>PART C – EDI BILLING SERVICE/CLEARINGHOUSE DATA (TO BE COMPLETED BY BILLING SERVICE/CLEARINGHOUSE)</b>	
Company Name:	
Address:	
City, State, Zip:	
Submitter ID:	E-mail:
Contact:	Phone: (    )      Ext:      Fax: (    )
Response Format: <input type="checkbox"/> File <input type="checkbox"/> Report Format	Mode: <input type="checkbox"/> ASYNCH <input type="checkbox"/> CONNECT:Direct <input type="checkbox"/> FTP
Data Compression: <input type="checkbox"/> PKZIP (Version 2.04g or compatible)	<input type="checkbox"/> UNIX <input type="checkbox"/> None

## **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 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 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
  - 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, 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 Social Security Act (the Act)).
14. That it will research and correct claim discrepancies.
15. That it will notify the carrier, MAC, 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' 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/Supplier Name: \_\_\_\_\_

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

\_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_

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

By (Print Name): \_\_\_\_\_

Title: \_\_\_\_\_

Railroad Medicare Provider Number: \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

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