MEDICARE PART B – CALIFORNIA SOUTH
PRE-ENROLLMENT INSTRUCTIONS – MR002

TO COMPLETE THIS FORM YOU WILL NEED:

- ✓ Medicare California South Provider Number (PTAN)
- ✓ Billing NPI on file with Palmetto for the California South PTAN
- ✓ Name and Address on file with Palmetto for the PTAN and Billing NPI

TO VERIFY THIS INFORMATION CONTACT PALMETTO AT 866-749-4301

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is approximately 4-6 weeks.

WHAT FORM SHOULD I DO?

- **EDI Enrollment Agreement Form – (see page 3 of these instructions for further instructions)**
  - For each unique Billing NPI (33A) there must be at least **ONE** EDI Enrollment Agreement form on file at Palmetto. When switching submitters, this form does not need to be completed again for Palmetto. EDI Enrollment Agreement forms must be signed by the provider (if the form is for a solo doctor) or the president, CEO, or owner of the group (if the form is for a group).

- **J1 EDI Application— (see page 4 of these instructions for further instructions)**
  - Anytime a provider switches from one submitter (clearinghouse) to another, a new J1 EDI Application must be completed to link the provider to the new submitter's Submitter ID

- **J1 Provider Authorization Form – (see page 5 of these instructions for further instructions)**
  - Every provider who authorizes a billing service and/or clearinghouse to act on their behalf must complete the Provider Authorization form. The form must be completed by the provider and submitted with the J1 EDI Application.

WHAT PROVIDER NUMBER DO I USE ON THE FORM(S)?

- Use one (1) provider number per form.

- If you are a group, list only your group name, group NPI and group provider number
  ***NEVER list rendering providers, rendering NPIs or rendering provider numbers anywhere on the form when filling out for a group practice**

- If you are an incorporated solo provider, list your corporation name, corporation NPI and corporation provider number

- If you are a solo provider (not incorporated), list your provider name, solo NPI and solo provider number

DO I NEED TO COMPLETE ALL FORMS?

- **If you have NEVER** submitted your Medicare Part B CA claims through Palmetto electronically through any clearinghouse you must complete both forms:
  - **EDI Enrollment Agreement** (3 pages – all pages are required to be included with submission)
  - **J1 EDI Application**
  - **J1 Provider Authorization Form**

- **If you WERE** already submitting your Medicare Part B CA claims through Palmetto electronically **through another clearinghouse, or directly** then you should already have completed an EDI Enrollment Agreement and you would just need to complete a new:
  - **J1 EDI Application** (if you had not completed an EDI Enrollment Agreement with Palmetto before, then you must complete an EDI Enrollment Agreement also)
  - **J1 Provider Authorization Form**

- **If you WERE** already submitting your Medicare Part B CA claims electronically **through Office Ally** then you would just need to complete:
  - **EDI Enrollment Agreement** (3 pages – all pages are required to be included with submission)

NOTICE OF APPROVAL

- Once notified of approval, provider must contact Office Ally PRIOR to submitting claims.

WHAT ABOUT ERAs?

- In order to receive ERA's from Palmetto through Office Ally, make sure to check the box on the J1 EDI Application (bottom of form) for Receive Electronic Remittances. If you do not wish to receive ERAs through Office Ally, do not check this box.

WHERE SHOULD I SEND THE FORMS?

- Forms should be mailed to:

  Palmetto GBA
  Jurisdiction 1, AG420
  PO Box 100145
  Columbia, SC 29202-3145

Note to My Clients Plus Users:

Once you have confirmed with the insurance payor that your provider number is linked to Office Ally please fax the following information to My Clients Plus at 888-653-7115.

- **My Clients Plus**
- **Provider/Practice Name as pre-enrolled with the insurance payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement "I have verified my provider ID has been linked to Office Ally with the Insurance Payor".**
- **Provider email address where you can be notified of setup completion.**

For Noridian Pre-Enrollments Please Also Include:

- **Submitter number**

HOW DO I COMPLETE THE EDI AGREEMENT FORM?

The agreement is 3 pages, with the fields to be completed located on page 3 of the agreement. All 3 pages of the agreement are required to be submitted or the application will be rejected. See below for additional details on how to complete page 3 of this agreement form.

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's Name: _____

Address: _____

_____

City/State/Zip: _____

Phone: _____

Authorized Signature: _____

By (Print Name): _____

Title: _____

Date: _____ Medicare Provider Number _____

National Provider Identifier (NPI): _____

Complete ALL fields above and mail entire agreement (three pages) with ***original*** signature and ***with*** a copy of the **EDI Application form** to:

All 3 pages of the agreement are required to be mailed.

Original signature required. Form must be signed by the provider (if the form is for a solo doctor) or the president, CEO, or owner of the group (if the form is for a group).

For each unique Billing NPI (33A) there must be at least ONE EDI Enrollment Agreement form on file at Palmetto. When switching submitters, this form does not need to be completed again for Palmetto. The Provider Number must be for Medicare Part B Southern California. The NPI but be the Billing NPI that is on file with Palmetto for the PTAN.

HOW DO I COMPLETE THE J1 EDI APPLICATION?

Anytime a provider switches from one submitter (clearinghouse) to another, a new J1 EDI Application must be completed to link the provider to the new submitter's Submitter ID. Most of all required fields are completed / pre-filled for you; however, there are additional sections that must be completed. See below for further details on how to complete this application.

Palmetto GBA
PARTNERS IN EXCELLENCE

Jurisdiction 1
Electronic Data Interchange Application

Line of Business Information: ☐ Part A ☒ Part B

☒ CA ☐ NV ☐ HI *(Note: Includes Samoa, Guam and Northern Mariana Islands)*

Action Requested: ☒ Add Provider(s) ☐ Change / Update Submitter Information
☐ Delete ☐ Apply for New Submitter ID

Submitter ID (if available): 000504222 **Date:** → **A date is required.**

Submitter Name: Office Ally

Owner Name: Brian O'Neill

Type of Submitter: ☐ Software Vendor ☐ Billing Service ☐ Provider ☒ Clearinghouse

EDI Contact Person: Customer Service

Phone: 866-575-4120 **Fax:** 360-896-2151

Address: PO Box 872020

City: Vancouver **State:** WA **ZIP:** 98687

Submitter E-mail Address: info@officeally.com

Note: E-mail will be the primary method of communication.

Claim Submission Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT: Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report / Electronic Remittance Retrieval Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT: Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report Response Format:	☒ File	☐ Report
Data Compression:	☐ Uncompressed (GPNet Default) ☒ PKZIP	☐ UNIX-Compress
Name of Software Vendor: OPTIONAL	**Vendor Security ID:** OPTIONAL	

Providers for Whom Submitter Will Be Transmitting: THIS SECTION IS IMPORTANT & MUST BE COMPLETED

Provider Name:

Provider E-mail Address:

Provider Number: **NPI:**

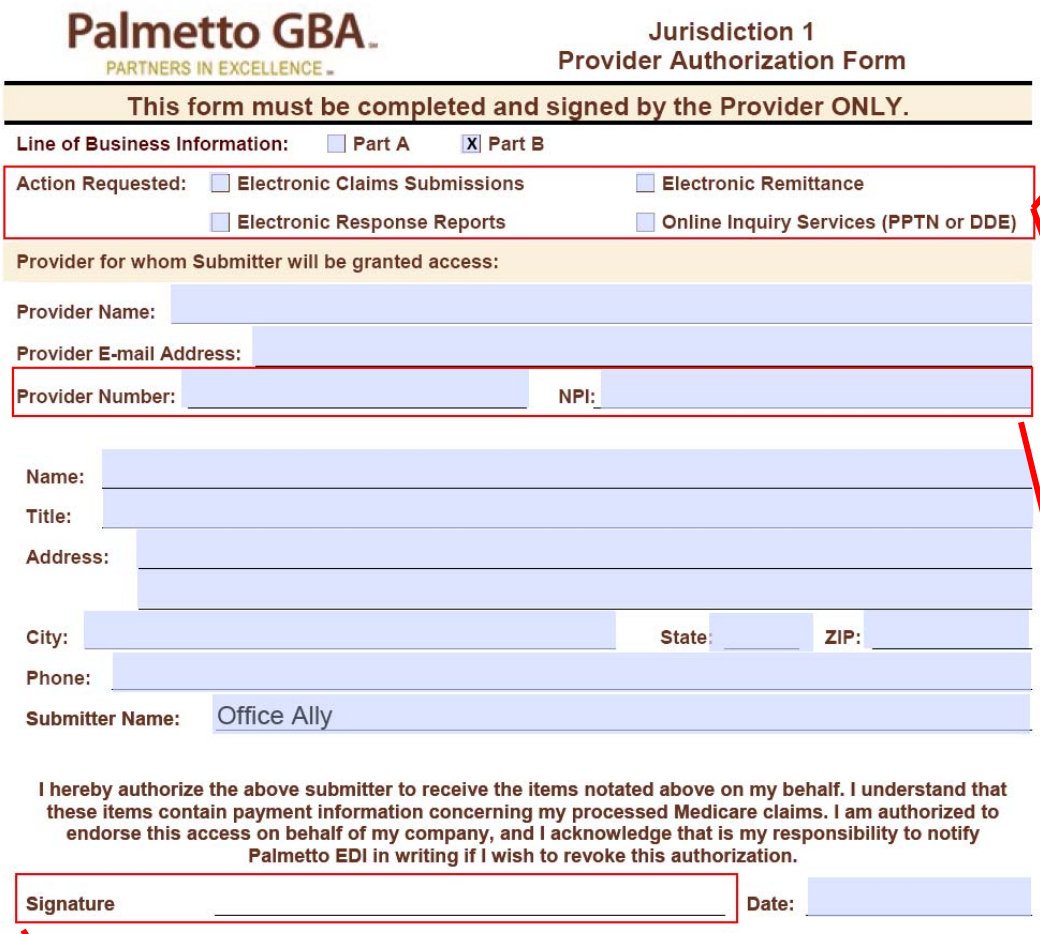
Enrollment Form Attached? ☐ Yes ☐ No **Provider Authorization Form Attached?** ☒ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

IF you are submitting the EDI Enrollment Agreement Form check "Yes". IF Palmetto already has this form on file and you are therefore are not re-submitting it then check "No".

You must select at least 1 of these actions. If only submitting claims then select "Electronic Claims Submissions". If you want to receive Response Reports or Electronic Remittances then check one or both of "Electronic Response Reports" and "Electronic Remittance". If you select Online Inquiry Services you must also complete a request form (do not include Office Ally information on this form). Click here for the form.

HOW DO I COMPLETE THE J1 PROVIDER AUTHORIZATION FORM?



Palmetto GBA
PARTNERS IN EXCELLENCE

Jurisdiction 1
Provider Authorization Form

This form must be completed and signed by the Provider ONLY.

Line of Business Information: ☐ Part A ☒ Part B

Action Requested: ☐ Electronic Claims Submissions ☐ Electronic Remittance
☐ Electronic Response Reports ☐ Online Inquiry Services (PPTN or DDE)

Provider for whom Submitter will be granted access:

Provider Name:

Provider E-mail Address:

Provider Number: NPI:

Name:

Title:

Address:

City: State: ZIP:

Phone:

Submitter Name: Office Ally

I hereby authorize the above submitter to receive the items notated above on my behalf. I understand that these items contain payment information concerning my processed Medicare claims. I am authorized to endorse this access on behalf of my company, and I acknowledge that is my responsibility to notify Palmetto EDI in writing if I wish to revoke this authorization.

Signature Date:

You must select at least 1 of these actions. If only submitting claims then select "Electronic Claims Submissions". If you want to receive Response Reports or Electronic Remittances then check one or both of "Electronic Response Reports" and "Electronic Remittance".

If you select Online Inquiry Services you must also complete a request form (do not include Office Ally information on this form). Click here for the form.

Only ONE (1) Provider Number and ONE (1) NPI per form. The Provider Number must be for Medicare Part B Southern California and the NPI number must be the billing NPI that Palmetto has on file with the PTAN provided.

An original signature is required. The signature must be of the provider (if for a solo doctor) or the president, CEO, or owner of the group (if for a group).

J1 EDI Application Form Instructions

The purpose of the **J1 EDI Application Form** is to enroll providers, software vendors, clearinghouses and billing services as electronic submitters and recipients of electronic claims data. **It is important that instructions are followed and that all required information is completed. Incomplete forms will be returned to the applicant, thus delaying processing.**

Please retain a copy of this completed form for your records.
You must submit a completed EDI Application Form when submitting additional EDI forms.

The field descriptions listed below will aid in completing the form properly. There are two (2) pages to the application form. The first page is required and the second page should be used only if additional providers need to be listed.

Form Field Name	Instructions for Field Completion
Line of Business Information	Indicate the line of business and states for which you will be transmitting. Select all that apply to this request.
Action Requested: Add Provider(s) Change/Update Submitter Information Delete Apply for New Submitter ID	Indicate the action to be taken on the application form. • If you need to add additional providers to an existing submitter ID, check **Add Provider(s)**. • If you request to change or update information about the Submitter, check **Change/Update Submitter Information** and be sure to include your current Submitter ID. • If you request to delete a provider(s), check **Delete** and be sure to include your submitter ID. • If you are a new applicant, check **Apply for New Submitter ID**.
Submitter ID	The submitter ID is used by the submitter to communicate with Palmetto GBA electronically. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID if requested. For changes or additions, enter the Submitter ID to which the change/additions should be applied.
Date	Please enter the date the application is completed.
Submitter Name	Enter the name of the entity (provider, software vendor, billing service or clearinghouse) that will actually be communicating electronically with Palmetto GBA.
Owner Name(s)	Enter the name of the individual(s) who owns the entity listed above.
Type of Submitter	Check the appropriate box.
EDI Contact Person	The name of the submitter's primary EDI contact. This is the person Palmetto GBA will contact if there are questions regarding the application or future questions about their communications.
Phone	The area code and phone number of the Contact Person listed.
Fax	The fax number for this location.
Address	The mailing address of the submitter.
City, State, ZIP	The city, state and ZIP code of the submitter.
Submitter E-mail Address	The e-mail address of the contact person listed. **Note: This will be the primary method of communication. This e-mail address will also receive EDI Tracking Numbers used to monitor the processing status of your EDI forms.**
Claim Submission Mode of Communication	There are four available modes of communication modes that can be used for claim submission. Check **only one**. • **GPNet**: Asynchronous communication with the Gateway • **Connect Direct – NDM**: Network Data Mover • **Dial-up FTP**: File transfer protocol transmission via GPNet – not Internet. • **Leased FTP:** File transfer protocol transmission via the Internet or Network-based connection.

Form Field Name	Instructions for Field Completion
Report / Electronic Remittance Retrieval Mode of Communication	Check **only one** mode of communication that will be used. • **GPNet Asynchronous** should be checked for asynchronous communication with Palmetto GBA's GPNet. • **CONNECT:Direct (NDM)** should be checked for report retrieval via GPNet • **Dial-up FTP** should be checked for file transfer protocol report retrieval via GPNet. • **Leased FTP:** File transfer protocol transmission via the Internet or Network-based connection.
Report Response Format	Check the format in which you will receive GPNet Claims Acceptance Reponses.
Data Compression	To receive files compressed for faster transmission, indicate which data compression utility you support.
Name of Software Vendor	Indicate the name of the software vendor you are using, if applicable.
Vendor Security ID	Include Vendor ID number if known.
Providers For Whom Submitter Will Be Communicating Electronically:	
Provider Name	List each provider whose bills will be submitted by the submitter named above. (If additional providers need to be listed, indicate each one separately on the *Multiple Providers List* form.) This name must match the name submitted on the CMS 855 Medicare Enrollment Application.
Provider E-mail Address	Indicate the e-mail address for the provider listed above. This e-mail address will be the primary source of communications regarding approval of changes to their EDI options.
Provider Number	Indicate the Medicare Provider Number for each provider listed.
NPI	Include the National Provider Identifier (NPI).
Enrollment Form Attached: Y/N	Indicate "Y" for Yes or "N" for No. A properly executed 3-page **EDI Enrollment Agreement** must be attached for *each* provider listed. **Palmetto GBA will not activate a submitter ID for any provider without a properly executed enrollment form**.
Provider Authorization Form Attached: Y/N	Indicate "Y" for Yes or "N" for No. A provider authorization form is required to authorize a clearinghouse and/or billing service as an electronic submitter and recipient of electronic claims data.
Submit Claims	Check this box if the application is for the submitter to submit claims electronically for this provider.
Receive Reports	Check this box if the submitter wants to receive response reports electronically for the provider indicated.
Receive Electronic Remittances	Check this box if the submitter wants to receive Electronic Remittances for the provider indicated. Provider must be submitting claims electronically to receive Electronic Remittances.
Online Inquiry	Check this box if the submitter currently uses or plans to use the Online Inquiry Services (DDE or PPTN). Note: The Online Inquiry Form must be submitted if this option is selected.

Once you have completed the application form, please retain a copy for your records and mail the original to the address listed below. Your Submitter ID and software (if applicable) will be processed within 20 business days of receipt of completed forms. Submit completed form to:

Palmetto GBA
J1 EDI Operations, AG-420
PO Box 100145
Columbia, SC 29202-3145

Palmetto GBA
PARTNERS IN EXCELLENCE

Jurisdiction 1
Electronic Data Interchange Application

Line of Business Information: ☐ Part A ☒ Part B

☒ CA ☐ NV ☐ HI *(Note: Includes Samoa, Guam and Northern Mariana Islands)*

Action Requested: ☒ Add Provider(s) ☐ Change / Update Submitter Information
☐ Delete ☐ Apply for New Submitter ID

Submitter ID (if available): 000504222 **Date:**

Submitter Name: Office Ally

Owner Name: Brian O'Neill

Type of Submitter: ☐ Software Vendor ☐ Billing Service ☐ Provider ☒ Clearinghouse

EDI Contact Person: Customer Service

Phone: 866-575-4120 **Fax:** 360-896-2151

Address: PO Box 872020

City: Vancouver **State:** WA **ZIP:** 98687

Submitter E-mail Address: info@officeally.com

Note: E-mail will be the primary method of communication.

Claim Submission Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT: Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report / Electronic Remittance Retrieval Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT: Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report Response Format:	☒ File	☐ Report
Data Compression:	☐ Uncompressed (GPNet Default) ☒ PKZIP	☐ UNIX-Compress
Name of Software Vendor:		**Vendor Security ID:**

Providers for Whom Submitter Will Be Transmitting:

Provider Name:

Provider E-mail Address:

Provider Number: **NPI:**

Enrollment Form Attached? ☐ Yes ☐ No **Provider Authorization Form Attached?** ☒ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

Submit completed form to:

Palmetto GBA
J1 EDI Operations, AG-420
PO Box 100145
Columbia, SC 29202-3145

Please retain a copy for your records.
You must submit a completed EDI Application Form when submitting additional EDI forms.

Palmetto GBA
PARTNERS IN EXCELLENCE

Jurisdiction 1
Electronic Data Interchange Application

Multiple Providers List

Date: ________________________

PROVIDERS FOR WHOM SUBMITTER WILL BE TRANSMITTING:

Provider Name: ______________________________

Provider E-mail Address: ______________________________

Provider Number: ____________________ **NPI:** ____________________

Enrollment Form Attached? ☐ Yes ☐ No **Provider Authorization Form Attached?** ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

Provider Name: ______________________________

Provider E-mail Address: ______________________________

Provider Number: ____________________ **NPI:** ____________________

Enrollment Form Attached? ☐ Yes ☐ No **Provider Authorization Form Attached?** ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

Provider Name: ______________________________

Provider E-mail Address: ______________________________

Provider Number: ____________________ **NPI:** ____________________

Enrollment Form Attached? ☐ Yes ☐ No **Provider Authorization Form Attached?** ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

Provider Name: ______________________________

Provider E-mail Address: ______________________________

Provider Number: ____________________ **NPI:** ____________________

Enrollment Form Attached? ☐ Yes ☐ No **Provider Authorization Form Attached?** ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

Please mail this form to:

Palmetto GBA
J1 EDI Operations, AG-420
PO Box 100145
Columbia, SC 29202-3145

Please retain a copy for your records. You must submit a completed EDI Application Form when submitting additional EDI forms.

J1 EDI Enrollment (Agreement) Form and Instructions

The J1 EDI Enrollment Form (commonly referred to as the EDI Agreement) should be submitted when enrolling for electronic billing. It should be reviewed and signed **only** by the providers to ensure each provider is knowledgeable of the enrollment request and the associated requirements.

Providers that have contracted with a third party (clearinghouse/network service vendor or a billing agent) are required to have an agreement signed by that third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to the viewing or use of Medicare Beneficiary data. These agreements are not to be submitted to Medicare, but are to be retained by the providers.

Providers are obligated to notify Medicare by letter of:

- Any changes in their billing agent or clearinghouse.
- The effective date of which the provider will discontinue using a specific billing agent or clearinghouse.
- If the provider wants to begin to use additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouse begins to use alternate software, the clearinghouse is responsible for notification in this instance.

Note: The binding information in an EDI Enrollment Form does not expire if the person who signed the form for a provider is no longer employed by the provider.

General Instructions:

- Please ensure that you include your **Medicare Provider Number** and **National Provider Identifier [NPI]** where requested on the EDI Enrollment Form.
- If the submitter will be submitting for multiple providers, this form must be completed by ***each*** provider whose claim data will be submitted.
- The entire form must be read carefully, dated with day, month and year.
- The name of the provider must be printed in the space provided, an authorized officer's name (printed), authorized officer's title and signature.
- When completed, the properly executed ***3-page*** **EDI Enrollment Form** must be returned ***with*** the **EDI Application** form to the following address:

  Palmetto GBA
  J1 EDI Operations, AG-420
  PO Box 100145
  Columbia, SC 29202-3145

Note: If the submitter will be an entity other than the provider, the submitter must complete the EDI Application form and the provider(s) must complete the EDI Enrollment Form(s). The EDI Application form must be returned with the EDI Enrollment Form enclosed for each applicable provider.

IMPORTANT NOTE:

The address shown on the EDI Enrollment Form must match the address that was submitted to our Provider Enrollment Department when enrolling for a provider number. If the address on the completed EDI Enrollment Form does not match, your entire EDI Enrollment Packet will be returned.

The National Provider Identifier (NPI) must be printed in the space provided on the EDI Enrollment Form. If this information is missing, the EDI Enrollment Form will not be processed.

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 contactor 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; and
   - 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 or 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 the Social Security Act (the Act);

14. That it will research and correct claim discrepancies;

15. That it will notify the carrier, MAC or 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's 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's Name: _____

Address: _____

_____

City/State/Zip: _____

Phone: _____

Authorized Signature: _____

By (Print Name): _____

Title: _____

Date: _____ Medicare Provider Number _____

National Provider Identifier (NPI): _____

Complete ALL fields above and mail entire agreement (three pages) with ***original*** signature and ***with*** a copy of the **EDI Application form** to:

Palmetto GBA
J1 EDI Operations, AG-420
PO Box 100145
Columbia, SC 29202-3145

Provider Authorization Form Instructions

The purpose of the notice is to authorize a clearinghouse and/or billing service as an electronic submitter and recipient of electronic claims data. It is important that instructions are followed and that all required information is completed. Incomplete forms will be returned to the applicant, thus delaying processing. Please retain a copy of this complete notice for your records.

Please retain a copy of this completed form for your records.
You must submit a completed EDI Application Form when submitting this form. The Provider Authorization form must be completed and signed by the Provider.

The field descriptions listed below will aid in completing the notice properly.

Form Field Name	Instructions for Field Completion
Line of Business Information	Indicate the line of business and states for which you will be transmitting. Select all that apply to this request.
Action Requested	Indicate the type of service(s) you are authorizing the Submitter to access. Check all that apply.
Provider Name	List the provider name for which this Provider Authorization Form is being completed. This name must match the name submitted on the CMS 855 Medicare Enrollment Application.
Provider E-mail Address	The e-mail address of the provider to receive EDI notifications.
Provider Number	List the provider PTAN whose Medicare claims, electronic remittances, response reports or PPTN/DDE will be accessed by the submitter listed on the EDI Application. A separate Provider Authorization Form is required for each PTAN.
NPI	Indicate the National Provider Identifier (NPI).
Name/Title	The name and title of the person Palmetto GBA will contact if there are questions regarding this Authorization Form.
Address	The mailing and/or the physical address of the provider. (Only one valid address has to be submitted.)
City, State, ZIP	The city, state and ZIP code of the provider.
Phone Number	The area code and phone number of the Contact Person listed.
Submitter's Name	The name of the Submitter you are authorizing for the above services.
Signature	The signature of the listed provider's authorized contact.
Date	The date the form was signed.

Palmetto GBA
PARTNERS IN EXCELLENCE

Jurisdiction 1
Provider Authorization Form

This form must be completed and signed by the Provider ONLY.

Line of Business Information: ☐ Part A ☒ Part B

Action Requested: ☐ Electronic Claims Submissions ☐ Electronic Remittance

☐ Electronic Response Reports ☐ Online Inquiry Services (PPTN or DDE)

Provider for whom Submitter will be granted access:

Provider Name: _____

Provider E-mail Address: _____

Provider Number: _____ **NPI:** _____

Name: _____

Title: _____

Address: _____

_____

City: _____ **State:** _____ **ZIP:** _____

Phone: _____

Submitter Name: _____

I hereby authorize the above submitter to receive the items notated above on my behalf. I understand that these items contain payment information concerning my processed Medicare claims. I am authorized to endorse this access on behalf of my company, and I acknowledge that is my responsibility to notify Palmetto EDI in writing if I wish to revoke this authorization.

Signature _____ **Date:** _____

Please complete and return this form, with the EDI Application Form, to:

Palmetto GBA
J1 EDI Operations, AG-420
PO Box 100145
Columbia, SC 29202-3145