Cortex EDI, Inc.

Fax

To: Karen	**From:** Cynthia
Fax: (714) 529-8562	**Pages:**
Phone: (800) 485-5977	**Date:** 5/2/2011

☑ **Urgent** ☐ Confidential

● **Comments:**

Karen,

Please MAIL ALL ORIGINAL SIGNED
(no copies)
enrollments for CA Medicare of Northern (ERN's) to:

CORTEX EDI
3 POINTE DRIVE, SUITE 201
BREA, CA 92821

If this is a doctor's office, please enter only your Group provider number and NPI.

Do NOT mail the enrollments to the insurance companies. Leave all submitter information blank.

Thank you,
Cynthia
Cortex EDI

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 ☐ Delete
☐ Apply for New Submitter ID ☐ Apply for PS&R ID

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

PPTN ID: _____ **DDE ID:** _____ **PS&R ID:** _____

Submitter Name: Cortex EDI, Inc.

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

Contact Person: _____

Phone: 714-529-8560 **Fax:** 714-529-8562

Address: _____

_____

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

E-mail Address: _____

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
PS&R Mode of Communication:	☒ GPNet Asynchronous	
Name of Software Vendor:		**Vendor Security ID:**
Online Inquiry Connectivity Vendor:	☐ IVANS ☐ VisionShare ☐ Other:	

Providers for Whom Submitter Will Be Transmitting:

Provider Name: _____

Provider Number: _____ **NPI:** _____

Enrollment Form Attached? ☐ Yes ☐ No

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

Submit completed form to: **Palmetto GBA**
Jurisdiction 1, AG-420
PO Box 100145
Columbia SC 29202-3145

Please retain a copy for your records.

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 Number: ____________________ **NPI:** ____________________

Enrollment Form Attached? ☐ Yes ☐ No

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

Provider Name: ____

Provider Number: ____________________ **NPI:** ____________________

Enrollment Form Attached? ☐ Yes ☐ No

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

Provider Name: ____

Provider Number: ____________________ **NPI:** ____________________

Enrollment Form Attached? ☐ Yes ☐ No

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

Provider Name: ____

Provider Number: ____________________ **NPI:** ____________________

Enrollment Form Attached? ☐ Yes ☐ No

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

Provider Name: ____

Provider Number: ____________________ **NPI:** ____________________

Enrollment Form Attached? ☐ Yes ☐ No

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

Please mail this form to:

Palmetto GBA
Jurisdiction 1, AG-420
PO Box 100145
Columbia, SC 29202-3145

Please retain a copy for your records.

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
Jurisdiction 1, 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: Cortex EDI, Inc.

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