PAYER ID: SRRGA **SUBMITTER ID:** RR1445

Change Healthcare CLAIM Provider Information Form

*This form is to ensure accuracy in updating the appropriate account

1 Provider Organization

Practice/ Facility Name		**Provider Name**			
Tax ID		**Client ID**		**Site ID**	V07S
Address		**City/State**		**Zip Code**	
Contact Name					
E-mail Address		**Telephone**		**Fax**	

2 Vendor *(Change Healthcare certified vendor used to submit files to Change Healthcare)*

Vendor Name	MD Claims Inc	**Vendor Submitter ID**	311349171	**Division ID**	na
Contact Name	Mike Dyas				
E-mail Address	mike@mdclaims.cc				

3 Payer

Payer ID	SRRGA RAILROAD MEDICARE	
Group ID	**Individual Provider ID**	**NPI ID**

4 Confirmations

Send Change Healthcare Claim Confirmations To:	mike@mdclaims.cc

Special Instructions:

- **All PayerRegistrationforms must contain signatures whenapplicable, stamped signatures or photocopies are accepted.**
- **SUBMIT COMPLETED FORM TO:**
  Fax: (615)231-4843
  Email: batchenrollment@Changehealthcare.com

CHANGE HEALTHCARE REVISION FORM DATE: 08/30/16

EDI APPLICATION FORM INSTRUCTIONS

The purpose of the **Railroad Medicare 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 for the services you are requesting 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.

Providers are not permitted to share their personal EDI access number (Submitter ID) or their password to:

- Any billing agent, clearinghouse/network service vendor
- To anyone on their own staff who does not need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility or to determine the status of a claim
- Any non-staff individual or entity

The EDI Submitter ID and password act as an electronic signature, therefore the provider would be liable if any entity performed an illegal action while using that EDI Submitter ID and password. Likewise, a provider's EDI Submitter ID and password is not transferable, meaning that it may not be given to a new owner of the provider's operation. New owners must obtain their own EDI Submitter ID and password.

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

Form Field Name	Instructions for Field Completion
Action Requested: Add New EDI Provider(s) Change/Update 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 New EDI Provider(s)**. • If you request to change/ 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**. • If you are a new applicant, check **Apply for New Receiver ID**.
Date	Enter today's date.
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. For changes or additions, enter the Submitter ID to which the change/additions should be applied.
ERN Receiver ID	The ERN Receiver ID is used to download electronic remittances. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID. For changes or additions, enter the ERN Receiver ID to which the change/additions should be applied.
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	Enter the name of the individual(s) who owns the entity listed above.
Type of Submitter	Check the appropriate box.
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.

Form Field Name	Instructions for Field Completion
Fax	The Fax number of the Contact Person listed.
Address	The mailing address of the submitter.
City, State, ZIP	The city, state, and ZIP code of the submitter.
Email Address	The Contact Person's email address. **Note: This will be the primary method of communication. This email address will also receive EDI Tracking Numbers used to monitor the processing status of your EDI forms.**
Request Response Format	Check the format in which you will receive GPNet Claim Acceptance Responses.
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 ID	Enter the Vendor ID assigned by Railroad Medicare, if applicable.
Name of Network Service Vendor	Indicate the name of the network service vendor you are using, if applicable.
Provider For Whom Submitter Will Be Transmitting	
Provider Name	List the provider whose bills will be submitted by the submitter named above.
Tax ID	Enter the Tax Identification Number for the provider.
Provider Email Address	Indicate the email address for the provider listed above. This email address will be the primary source of communications regarding approval of changes to their EDI options.
Railroad Medicare Provider Number	List the provider whose bills will be submitted by the submitter named above.
NPI	Include the National Provider Identifier (NPI).
Enrollment Attached?	Indicate "Y" for Yes or "N" for No. A properly executed 3-page **EDI Enrollment Agreement** must be attached for the provider listed. **Palmetto GBA will not activate a submitter ID for any provider without a properly executed EDI Enrollment Agreement**.
Provider Authorization Form Attached?	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.
Submit Claims	Check this box if the application is for the submitter to submit claims electronically for this provider.
Receive Electronic Remittances	Check this box if the submitter wishes to receive Electronic Remittances for the provider indicated. If this box is unchecked, the provider will be mailed hardcopy remittances.
Receive Reports:	Check this box if the submitter wants to receive response reports electronically for the provider indicated.

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 mailed within 15 business days of receipt of completed forms.

Completed forms must be faxed or emailed to:

Fax: **803**-382-2416*
*Please ensure you enter area code ***803*** when dialing our fax number.

Email: RREDI.ENROLL@PalmettoGBA.com

PALMETTO GBA
A CELERIAN GROUP COMPANY

Railroad Medicare
Electronic Data Interchange Application

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

Date: _____

Submitter ID: RR1445 ERN Receiver ID: ER1445

Submitter Name: CHANGE HEALTHCARE

Owner Name: SUZY CHANDLER

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

Contact Person: ENROLLMENT HELP DESK

Phone: 866.924.4634 Fax: 615.231.4843

Address: 3055 LEBANON PIKE SUTE 1000

City: NASHVILLE State: TN ZIP: 37214

Email Address*: PAYERREGISTRATION@CHANGEHEALTHCARE.COM
*Note: Email will be the primary method of communication.

Request Response Format:	☒ File	☐ Report
Data Compression:	☒ PKZIP	☐ UNIX-Compress

Name of Software Vendor: _____

Vendor ID (if applicable): _____

Name of Network Service Vendor _____

Provider For Whom Submitter Will Be Transmitting:

Provider Name: _____ Tax ID: _____

Provider Email Address: _____

Railroad Medicare Provider Number: _____ NPI: _____

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

☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports

Completed forms must be faxed or emailed to:

Fax: **803**-382-2416*
*Please ensure you enter area code ***803*** when dialing our fax number.

Email: RREDI.ENROLL@PalmettoGBA.com

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

EDI ENROLLMENT AGREEMENT INSTRUCTIONS

The Railroad EDI Enrollment Form (commonly referred to as the EDI Agreement) should be submitted when enrolling for electronic billing. It should be reviewed and signed by the provider, administrator or legal representative 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 **Railroad Medicare Provider Number** and **National Provider Identifier (NPI)** where requested on the EDI Enrollment Agreement. **Do not** enter your TAX ID Number.
- If a provider is a member of a group, only one agreement per group is required.
- 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 ***original*** signature.
- When completed, the properly executed ***3-page*** **EDI Enrollment Agreement** must be returned ***with*** the **EDI Application** form.
- Completed forms must be faxed or emailed to:

Fax: **803**-382-2416* Email: RREDI.ENROLL@PalmettoGBA.com

*Please ensure you enter area code ***803*** when dialing our fax number.

Note: If the submitter will be an entity other than the provider, the submitter must complete the Railroad Part B EDI Application form and the provider must complete the EDI Enrollment Agreement. The EDI Application form must be returned with the EDI Enrollment Agreement enclosed for each applicable provider.

IMPORTANT NOTICE PLEASE READ

The address shown on the EDI Enrollment Agreement must match the address that was submitted to our Provider Enrollment Department when enrolling for a Railroad Medicare Provider Number. If the address on the completed EDI Enrollment Agreement *does not* match, your entire EDI Enrollment Packet will be rejected and notification will be sent to the email address on the EDI Application Form.

The **National Provider Identifier (NPI)** must be printed in the space provided on the EDI Enrollment Agreement. If this information is missing, the **EDI Enrollment Agreement 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' A/B MACs or CEDI:

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 A/B MACs, DME MACs or CEDI 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 A/B MAC, DME MAC, CEDI 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 ID) of the provider on each claim electronically transmitted to the A/B MAC, CEDI 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 A/B MAC, DME MAC, CEDI 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 A/B MAC, DME MAC or CEDI (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 A/B MAC, CEDI, 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 A/B MAC, DME MAC, CEDI 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 A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the A/B MAC, CEDI or from any subsidiary of the A/B MAC, CEDI, other contractor if designated by CMS, or from any company for which the A/B MAC, CEDI has an interest. The A/B MAC, CEDI, 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 A/B MACs, CEDI, 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 sold directly, indirectly, or by arrangement by the A/B MAC, CEDI, or other contractor if designated by CMS;

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 A/B MAC, DME MAC, CEDI, 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 certify that I have been appointed an authorized individual to whom the provider has granted the legal authority to enroll it in the Medicare program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.) and to commit the provider to abide by the laws, regulations and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with Palmetto GBA on my behalf.

Provider Name: _____

Address: _____

_____

City/State/ZIP: _____

Authorized Signature: _____

By (Print Name): _____

Title: _____

Date: _____ Railroad Medicare Provider Number: _____

National Provider Identifier (NPI): _____

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

Fax: **803**-382-2416
Email: RREDI.ENROLL@PalmettoGBA.com

PROVIDER AUTHORIZATION FORM INSTRUCTIONS

The purpose of the form 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. This form is to be completed and signed by the provider. Forms completed and signed by a vendor, billing service or clearinghouse for a provider will not be processed. 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 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
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.
Tax ID	Enter the Tax Identification Number for the provider.
Provider Email Address	The email address of the provider to receive EDI notifications.
Railroad Medicare Provider Number	List the provider PTAN whose Medicare claims, electronic remittances or response reports will be accessed by the submitter listed on the EDI Application.
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.

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Railroad Medicare Provider Authorization Form

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

Action Requested: ☐ Electronic Claims Submissions ☐ Electronic Remittance
☐ Electronic Response Reports

Provider for whom Submitter will be granted access:

Provider Name: _____

Tax ID: _____

Provider Email Address: _____

Railroad Medicare Provider Number: _____ **NPI:** _____

Name: _____

Title: _____

Address: _____

_____

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

Phone: _____

Submitter Name: CHANGE HEALTHCARE

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 GBA EDI in writing if I wish to revoke this authorization.

Signature: _____ **Date:** _____

Please complete, sign and submit this form via fax or email, with the EDI Application Form, to:

Fax: **803**-382-2416

Email: RREDI.ENROLL@PalmettoGBA.com