
CGS Medicare States- Part A and B Kentucky, Ohio, and Home Health Hospice 837 and 835

EDI Enrollment Instructions:

- The billing provider must have an EDInsight customer account.
- The billing provider must be credentialed with Medicare and have an assigned Medicare PTAN in order to submit this request.
- If you have never submitted claims, you must also complete the attached EDI Enrollment Form. The Provider or Authorized Individual sign, print name, print title, and fax all pages of the form directly to the payer.
- EDI enrollment processing timeframe is approximately 7 days.
- Support Vendors may contact the EDInsight Enrollment Team or contact the applicable payer using the below numbers:
 - Medicare Part B- Call J15 Part B Provider Contact Center 1-866-276-9558
 - Medicare Part A- Call J15 Part A Provider Contact Center 1-866-590-6703
 - Home Health Hospice- Call J15 Provider Contact Center 1-877-299-4500

837 Claims Transactions and 835 Electronic Remittance Advice:

- Access the payer's website at:
https://www.cgsmedicare.com/medicare_dynamic/edi_application/edi_application/index.aspx.
- If it appears, on the '**LICENSES AND NOTICES**' window, click '**Accept.**'
- Complete all required fields on the '**EDI Application**' page:
 - Select '**Change/Update Submitter Information**' from the reason for submission menu.
 - Select the line of business based on the chart on Page 3.
 - Enter the corresponding submitter ID into the 837 and 835 fields.
 - Select '**Clearinghouse**' from the Type of Submitter menu.
 - Enter '**Practice Insight**' into the Submitter ID Entity Name field.
 - Enter '**Martha Johnson**' in the EDI Contact Person field.
 - Enter '**713-333-6000**' into the Submitter Phone Number field.
 - Enter '**pi-enrollment@waystar.com**' into the Submitter E-Mail Address field.
 - Enter '**713-333-0138**' into the Submitter Fax Number field.
 - Enter '**1 Greenway Plaza**' into the Submitter Address 1 field.
 - Enter '**Suite 350**' into the Submitter Address 2 field.
 - Enter '**Houston**' for Submitter City, '**TX**' for Submitter State, and '**77046**' for Submitter Zip.
- While still on the '**EDI Application**' page, please complete the '**Provider Information**' fields. You may ignore the '**Software Vendor & Network Service**' fields as they are not required.

- Click the **'Submit'** button.
- At the conclusion of the registration process, you will be presented with a printable version of the Provider Authorization Form. This form must be signed by the Provider **ONLY**.
 - You will be directed to a new page with a link to download an authorization form.
 - You **must** print this out, have it signed by the provider, add the TIN where indicated on the form, and fax or mail it to the fax numbers or address listed on the form.
 - If you do not complete this part of the enrollment within 5 days, your enrollment will be rejected and will need to be resubmitted as outlined in these instructions.

Within EDInsight- Enrollment Manager-

Take Action on the enrollment record and add note with details of submission.

LOGON to EDInsight- Enrollment Manager

ADD or SELECT payer enrollment record for the payer.

CLICK [**ADD Action Taken**], Select **WEBENROLL "Enrolled on Payer website"**

ENTER Note to indicate...*Online enrollment submitted on MM/DD/YYYY for PTAN # _____.*

(Please be sure to Provider # (aka PTAN #) entered on the online request for the billing

provider. The unique PTAN # will be needed in order for PI Enrollment to follow up or make

inquiries regarding the status of the EDI enrollment request.)

**CGS Medicare States- Part A and B
Kentucky, Ohio, and Home Health Hospice
837 and 835**

Table- Listing Medicare States with Payer ID, Payer ID, Medicare Contractor #, Submitter #.

Medicare State Part A or Part B	PI List Payer ID	Medicare Contractor#	Practice Insight Submitter ID #
Kentucky Part A	MAKY1	15101	CH15000006
Kentucky Part B	MBKY2	15102	ZEEF
Ohio Part A	MAOH1	15201	CH15000006
Ohio Part B	MBOH2	15202	N10046
Home Health & Hospice	MAHHH	15004	CH15000005

Medicare Electronic Data Interchange (EDI) Enrollment Agreement

- A.** The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' A/B MAC's or CEDI:
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 A/B MAC's, DME MACS or CEDI 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 Medicare beneficiary identifier
 - 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 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 identifier) 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, CEDI (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 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's policies;
 4. Ensure that no carrier, A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from 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 MAC, 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 the A/B MAC, CEDI, 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 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.

Attestation

The Trading partner has executed Business Associate Agreements (contracts), as mandated by HIPAA and ARRA/HITECH, with each of its business associates. Moreover, the trading partner attests that it has full responsibility, as mandated by HIPAA and ARRA/HITECH, for





EDI Enrollment (Agreement) Form & Instructions

notification of breaches of protected health information caused by the trading partner or its business associates.

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.

Group Practice/Provider Name:

Address:

City: **State:** **Zip:**

Phone:

Authorized Signature:

By (Print Name):

Title:

Date: **Group Medicare Provider Number:**

Group National Provider Identifier (NPI):

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

FAX completed form (for faster service) to:

1.615.664.5945	Ohio Part A	1.615.664.5943	Kentucky Part A
1.615.664.5927	Ohio Part B	1.615.664.5917	Kentucky Part B
1.615.664.5947	Home Health & Hospice		

Or mail completed form to:

J15 — Part B Correspondence
CGS
PO Box 20018
Nashville, TN 37202