General Completion Instructions for Electronic Data Request (EDR) Form

The Electronic Data Request (EDR) Form is designed for Medicare providers to apply for or revise existing information pertaining to the Electronic Remittance Advice (ERA) or the Electronic Claim Status (ECS) Request and Response transaction. **Prior to applying for one of these transactions, check with your software support vendor to ensure you have the necessary software to conduct the transaction.**

Please review the following completion instructions carefully to ensure all required information is provided. If all required information is not provided, the form will be returned to the provider for the additional information.

SECTION A: Request Type. This section is required.

New Submitter: If you do not have a submitter number to transmit or receive electronically, a New Installation/Change of Vendor Form is required prior to being set up to receive electronic remittances or electronic claim status. You may submit this form (EDR) with the New Installation/Change of Vendor Form. Indicate in this section which transaction you are applying for.

Existing Submitter: If you currently have a submitter number, indicate which transaction you want to add or delete. Please note the PC-ACE Pro32® software does not support the electronic claim status transaction.

SECTION B: Submitter Information. All fields in this section are required unless otherwise indicated.

The submitter information refers to the entity that will conduct the electronic exchange of the transaction. Third party billers need to apply for their own submitter number. **A third party biller <u>cannot</u> use a Medicare Provider's assigned Submitter number**.

Submitter Number (Conditional): Indicate the submitter number that will be used to transmit or receive electronic transactions. Required when adding a transaction to or deleting a transaction from an existing submitter number.
Submitter Name: Indicate the name of the submitter.
Mailing Address: Indicate the address of the submitter.
City/State/ZIP: Indicate the city, state and ZIP for the submitter's address indicated above.
Contact Name/Position or Title: Indicate the name and title of the person to be contacted in case of inquiries concerning this form.
Telephone: Indicate the telephone number of the submitter in case of inquires concerning this form.

Fax/Email Address (Optional): Indicate the fax number and email address of the submitter in case of inquires concerning this form.

SECTION C: VENDOR INFORMATION. All fields in this section are required unless otherwise indicated.

Vendor Name: Indicate the software support vendor's name.
Vendor Address (Optional): Indicate the software support vendor's address.
City/State/ZIP (Optional): Indicate the software support vendor's city, state and ZIP for the address as shown above.
Contact Name/Position/Title (Optional): Indicate the name and title of the contact person for the software support vendor.
Telephone and Fax Number (Optional): Indicate the contact person's telephone and fax number.

SECTION D: DEFAULT DELIMITERS (Optional): Please contact your software support vendor for information about the default delimiters. If your software supports the default delimiters, please leave blank. If you are using the PC-ACE Pro32® software, leave blank.

SECTION E: Signature, Title, Provider's Name, Effective Date, National Provider Identifier (NPI), Provider's Tax Identification Number / Social Security Number. All fields in this section are required.

The signature of the provider or authorized party for the provider is required. Indicate the title of the provider or authorized party, Medicare provider's name, the effective date to begin receiving electronic remittances/claim status and response, the provider's NPI (if the provider is a member of a group indicate the group's NPI), and the provider's Tax Identification Number / Social Security Number used to bill for the provider.

NOTE: When the provider is using a third party, e.g., clearinghouse, billing service, etc., to exchange EDI transactions, the signature serves as the provider's authorization for that third party to act on behalf of the provider for the indicated EDI transaction(s). The provider is required to have on file, an agreement signed by the 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 viewing or use of Medicare beneficiary data. **A representative from a billing service or clearinghouse is not authorized to sign on behalf of the provider.**

FIRST COAST SERVICE OPTIONS, INC.
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

CMS CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE
Electronic Data Interchange

ELECTRONIC DATA REQUEST (EDR) FORM

SECTION A: REQUEST TYPE. Please Check One. This section is required.

New Submitter: (New Installation/Change of Vendor Form is required to accompany this request.)

_____ ADD ELECTRONIC REMITTANCE ADVICE ASC X12N 835 version 4010A1

_____ ADD ELECTRONIC CLAIMS STATUS REQUEST AND RESPONSE ASC X12N 276/277 version 4010A1 (Not supported by PC-ACE Pro32® software)

Existing Submitter: (A submitter number has already been issued.)

X ADD ELECTRONIC REMITTANCE ADVICE ASC X12N 835 version 4010A1

_____ DELETE ELECTRONIC REMITTANCE ADVICE ASC X12N 835 version 4010A1

_____ ADD ELECTRONIC CLAIMS STATUS REQUEST AND RESPONSE ASC X12N 276/277 version 4010A1 (Not supported by PC-ACE Pro32® software)

_____ DELETE ELECTRONIC CLAIMS STATUS REQUEST AND RESPONSE ASC X12N 276/277 version 4010A1

NOTE: ***The provider is required to have a signed EDI Enrollment Form on file. Failure to have an EDI Enrollment form on file will result in the EDR form being returned.***

SECTION B: SUBMITTER INFORMATION. All fields in this section are required unless otherwise indicated.

Submitter Number (Conditional): P3499
(Required when adding or deleting a transaction to an existing submitter)

Submitter Name: EClaims, Inc

Mailing Address: 2201 Central Ave. Suite D

City/State/ZIP: Kearney, NE 68847

Contact Name: Client Services Position/Title: Client Services

Telephone: 308-698-5400 EXT. _____

Fax (Optional): 206-666-3955 Email Address (Optional): _____

SECTION C: VENDOR INFORMATION. The software support vendor can assist with this section. **All fields in this section are required unless otherwise indicated.**

Vendor Name: _____

Vendor Address (Optional): _____

City/State/ZIP (Optional): _____

Contact Name (Optional): _____ Position/Title (Optional): _____

Telephone Number (Optional): _____ Fax Number (Optional): _____

SECTION D (Optional): DEFAULT DELIMITERS. Contact your software support vendor for assistance with this section. If you are using the PC-ACE Pro32® software, leave blank. If your software supports the default delimiters, please leave blank.

The default delimiters returned on electronic remittance advice are:

- * (2A hex value) for element delimiter;
- > (3E hex value) for sub-element delimiter; and
- Line Feed (0A hex value) for segment delimiter.

If alternate values are required, please indicate below:

Element _____ Sub-element _____ Segment _____

SECTION E: PROVIDER'S SIGNATURE, TITLE, MEDICARE PROVIDER'S NAME, EFFECTIVE DATE, NPI (if the provider is a member of a group indicate the group's NPI)**, PROVIDER'S TAX IDENTIFICATION / SOCIAL SECURITY NUMBER: This section is required.** Please copy and complete this page for each additional provider.

"By signing below, I authorize the indicated electronic data request addition or deletion.

X_____**/**_____

(Signature) **(Title)**

MEDICARE PART "A" PROVIDER:_____

Name of Provider

MEDICARE PART "B" PROVIDER: _____

Name of Provider

EFFECTIVE DATE: _____ **NPI:** _____

(National Provider Identifier)

PROVIDER'S TAX IDENTIFICATION NUMBER / SSN: _____

****Attention: The provider is required to notify Medicare EDI, in writing, in advance of any changes impacting their use of EDI and the effective date of such changes. Medicare EDI must be notified if the provider will begin, change, or discontinue using a billing service, clearinghouse, or other third party. The form necessary to notify us of such changes is the EMC Change of Information form that can be downloaded from the Web site www.fcso.com, select Electronic Services.**

If you have questions about the completion of this form, please refer to the "General Completion Instructions" of the EDR form.

Mailing Address:
Medicare EDI
PO Box 44071 – 14T
Jacksonville, FL 32231-4071

Phone and Fax Numbers:
Phone: 1-888-670-0940, option 4
Fax: 904-361-0470

Physical Address:
Medicare EDI
532 Riverside Ave. 14T
Jacksonville, FL 32202-4918