North Dakota Medicare

Complete form, sign and mail original to:
Noridian Administrative Services, LLC (NAS)
EDI Support Services
PO Box 9319
Fargo, ND 58106-9319

Blank forms may by copied.

Call LTC at 888-941-8967 if you have questions.

4010A1 (837P) Professional Claim Registration Form Completion Instructions

These instructions will assist you in completing the 837P Professional Claim Registration, Version 4010A1 form. The information provided will be used to set your facility up for testing the 4010A1 version of electronic claims. All sections must be filled out. **Print legibly and complete every section as accurately as possible.** If a section is not applicable, write "N/A". If you have any additional questions, contact EDI Support Services (EDISS) at (800) 967-7902.

> ⚠ DO NOT use this form if you are currently registered with EDISS and have received your 10 digit National Provider Identifier (NPI). Please submit the "NPI Update Request Form" in place of this Exhibit A. If you have any questions about which form to complete, please contact EDISS at (800) 967-7902.

PROVIDER INFORMATION

1. This date indicates when the provider will be ready to begin the Health Care Professional Claim transaction.
2. Provide the Federal Tax ID of the provider.
3. Provide the 10 digit National Provider Identifier (NPI), if one has been assigned.
4. The Lines of Business (LOB) section will indicate for which LOBs this provider is requesting the 837P. Fill out the appropriate blanks for each LOB with the appropriate billing/clinic number, and check the one state that applies for that LOB. (For vendors participating in the Medicare Competitive Acquisition Program For Part B Drugs and Biologicals enter your U.S. state code on the line provided.) Only one billing provider/clinic number can be entered for each LOB. If multiple numbers need to be entered for a single LOB then a separate registration form must be completed. TriWest (TriCare) providers are instructed to provide the Federal Tax ID to identify a group or solo provider. For North Dakota Workforce Safety & Insurance the corresponding billing number should be the provider's 9-digit Federal Tax ID and his/her 3-digit Location Code.

FACILITY INFORMATION

5. Fill in all of the blanks with the requested information for the provider/clinic that is applying for electronic claim submission.

VENDOR INFORMATION

6. PC-ACE Pro32 is EDISS's low-cost billing and remittance advice viewing/printing software solution. If you plan on using this software please indicate this by placing a checkmark in the correct box. If you marked "No" for the PC-ACE Pro32, fill out the software vendor information section with the information requested. If your facility utilizes a billing service or clearinghouse, fill out the applicable section.
    a. Software Vendor - An entity that supplies the medical billing software used within your office for electronic submissions.
    b. Billing Service - An entity that creates the actual claims on behalf of the provider and sends them to EDISS.
    c. Clearinghouse - An entity that receives provider data, then translates and forwards the data to EDISS.
7. If the provider would like to receive an electronic remittance advice (835) in the ANSI 4010A1 version, check the "Yes" box; you must also complete the Exhibit A, 835 registration form and forward it to EDISS. If the provider does not choose to receive an electronic remittance, check the "No" box; an Exhibit A, an 835 registration form is not required.
8. The method of electronic access indicates the actual connection to EDISS being requested.
    a. Direct Dial Up - Choose this option if the Trading Partner plans to dial EDISS's test/production phone lines directly. These numbers may be long distance and all charges will be the responsibility of the provider. If this option is selected, indicate the protocol that will be used in the connection. If the protocol being used is not known, Zmodem is a default.
    b. Internet/Web Portal - EDISS will support the use of the Internet to submit transactions for **Iowa Medicaid line of business ONLY**. This web page is not able to accept non-Iowa Medicaid transactions at this time.
    c. IVANS or VisionShare are companies that offer connection alternatives to dialing EDISS directly.
        - IVANS offers a single connection for multiple HIPAA transactions. IVANS has many connecting phone numbers and may have a toll free number in your area. For more information on IVANS, go to www.noridianmedicare.com.
        - VisionShare offers a high-speed, secure, connection alternative to direct dial. This network-based connectivity eliminates the need for modems. For more information on VisionShare, go to www.noridianmedicare.com.

ORIGINAL SIGNATURE

9. The signature section needs to be filled out completely and signed in ink by the provider. If the provider's signature is not available, a signature of someone from the facility holding a management position or higher will be accepted. If the provider/facility has been assigned a group provider/clinic number, EDISS requires the signature of the individual who has the authority to enter into contracts on behalf of the group. **The form with an original ink signature must be mailed to EDISS to avoid any interruptions in your ability to exchange data with EDISS.**

Exhibit A
837P Registration 4010A1

837P PROFESSIONAL CLAIM REGISTRATION, VERSION 4010A1	
Noridian Administrative Services, LLC (NAS) **EDI Support Services** **PO Box 9319** **Fargo, ND 58106-9319**	**Phone number: (800) 967-7902** **Contact us via e-mail at: edi@noridian.com** **Visit our website at: www.noridianmedicare.com**

The information you provide on this EDI registration is used to set your facility up for electronic 837 Professional claims submission. **Print legibly and complete every section as accurately as possible.** If a section is not applicable, write "N/A". If you have any questions concerning the correct completion of the form, please contact us for assistance. Once you are approved for EDI production status, notify us by using the Electronic Claims Termination/Change Form whenever this information changes.

Faxed copies of this form will not be accepted.

PROVIDER INFORMATION

1. What date would you like to begin the Health Care Professional Claim transaction? _____ / _____ / _____

2. Federal Tax ID: _____

3. NPI: _____

4. Select all lines of business that apply. Fill in the blank with the appropriate billing provider/clinic number.

Lines of Business

Medicare B *(check one)*

☐ AK ☐ AZ ☐ CO ☐ HI ☐ IA ☑ ND
☐ NV ☐ OR ☐ SD ☐ WA ☐ WY ..... **Billing Provider/Group #:** _____

Medicare B Drugs and Biologicals *(for CAP vendors only)*

U.S. State Code: _____ ..... **Vendor #:** _____

Medicaid *(check one)*

☐ IA ☐ ND ..... **Billing Provider/Group #:** _____

TriWest (TriCare) *(check one)*

☐ ND ☐ WY ..... **Federal Tax ID:** _____

Workforce Safety & Insurance

☐ ND..... **Billing Provider #:** _____ / _____
Federal Tax ID Location Code

Blue Shield *(check one)*

☐ ND ☐ WY ..... **Clinic #:** _____

North Dakota Vision Services, Inc. ☐ ND ..... **Clinic #:** _____

Exhibit A
837P Registration 4010A1

FACILITY INFORMATION

5. Please fill in the facility information for the provider/clinic that will be sending electronic claims.

Name: _____
Mailing Address: _____
City: _____ **State:** _____ **Zip:** _____
Physical Address: _____
City: _____ **State:** _____ **Zip:** _____
Contact: _____
Telephone: ( ) _____ **Fax:** ( ) _____
E-Mail: _____

VENDOR INFORMATION

6. Do you want to order PC-ACE Pro32 software for use in your office? ☐ Yes ☑ No ☐ Already Using

(If yes, please fill out a PC-ACE Pro32 Software License Agreement. If no, please inform us of what software you will be using.)
(PC-ACE Pro32 is available to download free of charge from our website. Noridian requires a $25.00 yearly fee from anybody requesting the PC-ACE Pro32 program on Compact Disc (CD). This fee will cover the shipping and handling of the software and its continuing updates. This fee is an annual fee allowed by the Centers for Medicare and Medicaid Services (CMS).)

Software Vendor Information

Vendor Name: N/A
Software Product Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Contact: _____
Telephone: ( ) _____ **Fax:** ( ) _____

Billing Service Information

Billing Service Name: N/A
Software Product Name: _____
Address: _____
City: _____ **State:** _____ **Zip:** _____
Contact: _____
Telephone: ( ) _____ **Fax:** ( ) _____

Clearinghouse Information

Clearinghouse Name: Lindsay Technical Consultants, Inc.
Software Product Name: LTC Proprietary
Address: 42496 Lindsay Drive
City: North Mankato **State:** MN **Zip:** 56003
Contact: Gary Lindsay
Telephone: (507) 947-3070 **Fax:** (507) 947-3077

VENDOR INFORMATION (cont.)

7. Do you want to receive an Electronic Remittance Advice (ERA*)?
   ** An ERA is an electronic copy of the payment data received on the paper remittance. You must have a software program to print or post this data.*
   ☐ Yes ☑ No (If yes, fill out the Exhibit A, 835 Health Care Claim Payment/Advice Form.)

8. **Method of Electronic Access** *(check one)*
   ☑ Dial-Up (if dial-up, check desired protocol below)
   ☑ Zmodem ☐ Ymodem ☐ Kermit ☐ Other_____
   ☐ Internet/Web Portal (Internet submissions for the Iowa Medicaid line of business ONLY)
   ☐ IVANS (please refer to the IVANS section of our website at: www.noridianmedicare.com)
   ☐ VisionShare (please refer to the VisionShare section of our website at: www.noridianmedicare.com)

ORIGINAL SIGNATURE

9. An appropriate original ink signature (refer to the Form Completion Instructions) is required for this document. Blue ink is preferred. **The form with an original ink signature must be mailed to EDISS to avoid any interruptions in your ability to exchange data with EDISS.**

   As a member of this organization, I am authorized to sign this document on behalf of the provider/facility, and I authorize the set-up noted above for the 837P Professional Claim transaction.

   Signature: _____
   Print name: _____
   Title: _____
   Date: _____/_____/_____

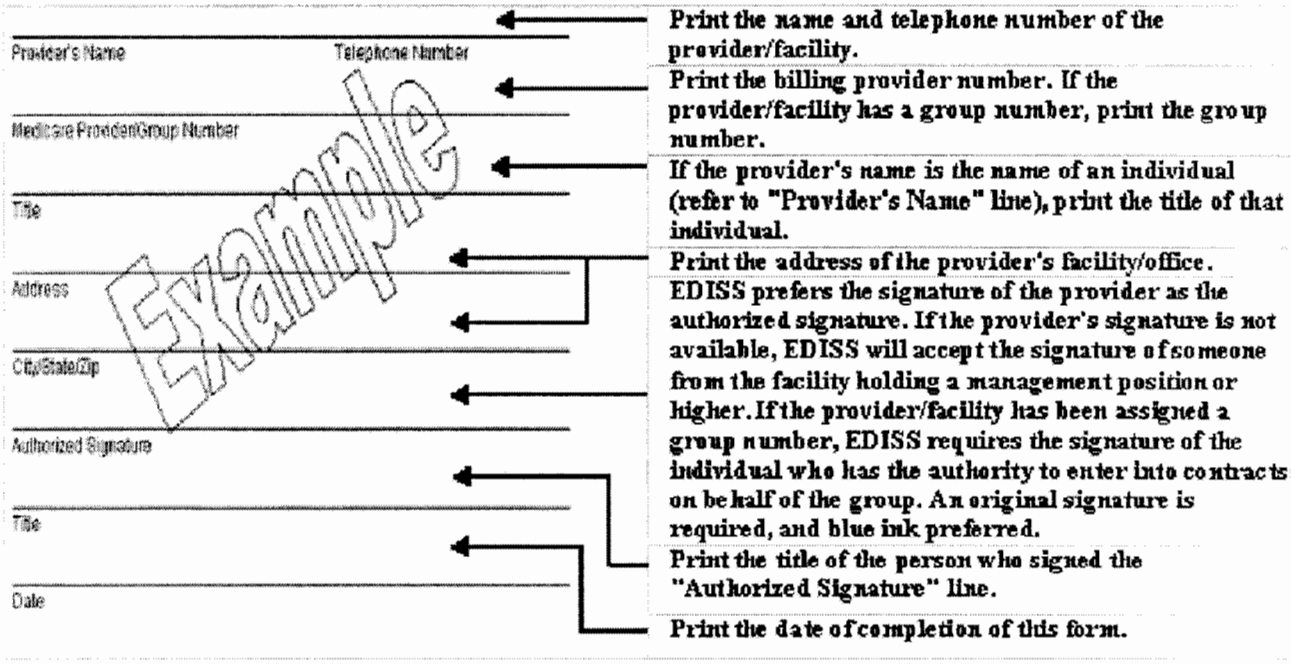
Noridian EDI Support Services EDI Enrollment Form Completion Instructions

These instructions will assist you in completing the Electronic Data Interchange (EDI) Enrollment Form. All sections must be filled out. **Print legibly and complete every section as accurately as possible.** Although this document is to aid you in the completion of this form, if you have questions, please contact EDI Support Services (EDISS) at 800-967-7902.

SIGNATURE SECTION

On page two of the EDI Enrollment Form, there is a signature section. The signature section needs to be filled out completely and signed in ink by the provider. If the provider's signature is not available, a signature of someone from the facility holding a management position or higher will be accepted. If the provider/facility has been assigned a group provider/clinic number, EDISS requires the signature of the individual who has the authority to enter into contracts on behalf of the group. **The form with an original ink signature must be mailed to EDISS to avoid any interruptions in your ability to exchange data with EDISS.**

In the signature section, there are eight lines that need to be completed. Below is an excerpt of the EDI Enrollment Form. Complete each line on the form per the instructions.



Print the name and telephone number of the provider/facility.

Print the billing provider number. If the provider/facility has a group number, print the group number.

If the provider's name is the name of an individual (refer to "Provider's Name" line), print the title of that individual.

Print the address of the provider's facility/office.

EDISS prefers the signature of the provider as the authorized signature. If the provider's signature is not available, EDISS will accept the signature of someone from the facility holding a management position or higher. If the provider/facility has been assigned a group number, EDISS requires the signature of the individual who has the authority to enter into contracts on behalf of the group. An original signature is required, and blue ink preferred.

Print the title of the person who signed the "Authorized Signature" line.

Print the date of completion of this form.

To avoid any interruptions in your ability to exchange data with EDISS, mail **BOTH first and second pages** of the completed EDI Enrollment Form to:

EDI Support Services
PO BOX 9319
Fargo, ND 58106-9319

Electronic Data Interchange (EDI) Enrollment Form

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' contractors.

A. <u>The Provider Agrees</u>:

1. That it will be responsible for all Medicare claims submitted to CMS 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 contractors, 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 contractor 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-signed unique identifier number of the provider on each claim electronically transmitted to the contractor.

10. That the CMS-assigned unique identifier number constitutes the provider's legal electronic signature and an assurance by the provider that services were performed as billed.

11. That it will use sufficient security procedures 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 contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

14. That it will research and correct claim discrepancies.

15. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. **The Centers for Medicare & Medicaid Services Agree To:**

1. Transmit to the provider an acknowledgement of claim receipt.

2. Affix the intermediary/carrier 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 contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor 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 contractors 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 contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

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 CMS or the contractor. Either party may terminate this arrangement by giving the other party (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 EDI Enrollment Form 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 Phone Number

_____

Medicare Provider/Group Number

_____

Title

_____

Address

_____

City/State/Zip

_____

Authorized Signature

_____

Title

_____

Date

NOTE: Please send both pages of this completed EDI Enrollment Form to EDI Support Services at PO Box 9319, Fargo, ND 58106-9319.