Ohio Medicare Part B Change Form
Change form for currently enrolled providers changing to new clearinghouse(LTC).

Complete the form, sign, and mail original to:
CGS
1 Cameron Hill Cir STE 0061
Chattanooga, TN 37402-0061

Blank forms may be copied.

Call Lindsay Technical Consultants, Inc. (888) 941-8967, if you have any questions.

Palmetto GBA EDI
OH and WV Part B Provider Change Form

This form is to be completed by a Provider when the following changes occur:

☐ Discontinue use of a billing agent or clearinghouse
☐ Use of a new billing agent or clearinghouse

Required fields are noted with an asterisk (*).

* Provider Name: _____
* Contact Name: _____
* Mailing Address: _____
_____

* City: _____ * State: _____ * ZIP: _____
* Phone #: _____ FAX #: _____
* E-mail Address: _____
* Provider Number: _____
*NPI: _____

Transaction(s) Affected: ☐ ANSI 837 Claim ☐ ANSI 835 Remittance
☐ ANSI 276/277 Claim Status

Previous Billing Service/Clearinghouse Agent Name: _____
Submitter ID of Billing Service/Clearinghouse (if available): _____
End Date (if applicable): _____

New Billing Service/Clearinghouse Agent Name: _____
Submitter ID or address of Billing Service/Clearinghouse: _____
Begin Date (if applicable): _____

*Authorized Signature _____
*Printed Name _____
*Title _____
*Date _____

If you have any questions, please contact the Palmetto GBA OH/WV Technical Support Team at 1-866-308-5438.

Please mail the completed form to:

Palmetto GBA

Government Programs Electronic Data Interchange (EDI) Operations
PO Box 182934 • Columbus • Ohio • 43218-2934

A CMS Contracted Intermediary and Carrier

EDI Application Form Instructions

The purpose of the **Ohio & West Virginia Part B 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. There are two (2) pages to the application form. The first page is required and the second page should be used only if additional providers need to be listed.

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** 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**.
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.
Date	Please enter the date the application is completed.
Submitter Name	Enter the name of the entity (provider, software vendor, billing service or clearinghouse) that will actually be communicating electronically with Palmetto GBA.
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.
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.

Form Field Name	Instructions for Field Completion
E-mail Address	The Contact Person's e-mail address. **Note: This will be the primary method of communication.**
Claim Submission Mode of Communication	There are three available modes of communication that can be used for claim submission: **Check only one**. • **GPNet**: Asynchronous communication with the Gateway • **Connect Direct – NDM**: Network Data Mover • **Dial-up FTP**: File transfer protocol transmission via GPNet-not Internet
Report/Electronic Remittance Retrieval Mode of Communication	Check **only one** mode of communication that will be used. • **GPNet Asynchronous** should be checked for asynchronous communication with Palmetto GBA's GPNet. • **CONNECT:Direct** (NDM) should be checked for report retrieval via GPNet. • **Dial-up FTP** should be checked for file transfer protocol report retrieval via GPNet.
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.
Providers For Whom Submitter Will Be Communicating Electronically:	
Provider Name	List each provider whose bills will be submitted by the submitter named above. (If additional providers need to be listed, indicate each one separately on the *Multiple Providers List* form.)
Provider Number	Indicate the 7-character Group Medicare Provider Number or 7-character Solo Practice Medicare Provider Number for each provider listed.
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 *each* provider listed. **Palmetto GBA will not activate a submitter ID for any provider without a properly executed EDI Enrollment Agreement**.
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 20 business days of receipt of completed forms.

Submit completed form to: CGS   1 Cameron Hill Cir STE 0061   Chattanooga, TN 37402-0061

Palmetto GBA
PARTNERS IN EXCELLENCE

Ohio & West Virginia Part B
Electronic Data Interchange Application

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

Submitter ID: _____   **Date:** _____

Submitter Name: _____

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

Contact Person: _____

Phone: _____   **Fax:** _____

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**
Report/Electronic Remittance Mode of Communication:	☐ **GPNet Asynchronous** ☐ **Connect Direct: (NDM)**	☐ **Dial-up FTP**
Request Response Format:	☐ **File** ☐ **Report**	
Data Compression	☐ **PKZIP** ☐ **UNIX-Compress**	
Name of Software Vendor:		

Providers For Whom Submitter Will Be Transmitting:

Provider Name: _____

Provider Number: _____   **NPI:** _____

Enrollment Attached?   ☐ **Submit Claims**   ☐ **Receive Electronic Remittances**   ☐ **Receive Reports**
☐ **Yes**   ☐ **No**

Provider Name: _____

Provider Number: _____   **NPI:** _____

Enrollment Attached?   ☐ **Submit Claims**   ☐ **Receive Electronic Remittances**   ☐ **Receive Reports**
☐ **Yes**   ☐ **No**

Completed forms must be mailed to us at the following address:

CGS

1 Cameron Hill Cir STE 0061

Chattanooga, TN 37402-006

> **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

Ohio & West Virginia Part B
Electronic Data Interchange Application

Multiple Providers List

Date: _____

PROVIDERS FOR WHOM SUBMITTER WILL BE TRANSMITTING:

Action Requested: ☐ Add Provider ☐ Change ☐ Delete Provider
Provider Name: _____

Provider Number: _____ **NPI:** _____
Enrollment Attached? ☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports
☐ Yes ☐ No

Action Requested: ☐ Add Provider ☐ Change ☐ Delete Provider
Provider Name: _____

Provider Number: _____ **NPI:** _____
Enrollment Attached? ☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports
☐ Yes ☐ No

Action Requested: ☐ Add Provider ☐ Change ☐ Delete Provider
Provider Name: _____

Provider Number: _____ **NPI:** _____
Enrollment Attached? ☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports
☐ Yes ☐ No

Action Requested: ☐ Add Provider ☐ Change ☐ Delete Provider
Provider Name: _____

Provider Number: _____ **NPI:** _____
Enrollment Attached? ☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports
☐ Yes ☐ No

Action Requested: ☐ Add Provider ☐ Change ☐ Delete Provider
Provider Name: _____

Provider Number: _____ **NPI:** _____
Enrollment Attached? ☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports
☐ Yes ☐ No

Action Requested: ☐ Add Provider ☐ Change ☐ Delete Provider
Provider Name: _____

Provider Number: _____ **NPI:** _____
Enrollment Attached? ☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports
☐ Yes ☐ No