Advanced Billing Consultants, Inc.

New Client Workbook

New Client Worksheet & Technical Information Worksheet

New Client Worksheet

Please fill out this form completely and email it to forms@advancedbillingconsultants.com or fax to 949.713.2931

Client/Practice Name:

Specialty:

Office Address:

Office Phone #:

Office Fax #:

Office Manager Name:

Office Manager Email:

Credit Cards Accepted: Visa MasterCard Amex Discover

Please provide each provider's name, NPI and email address in the corresponding boxes below

Provider Name	NPI	Email Address

Please provide the practice tax ID, NPI, and PTAN in the corresponding boxes below

Tax ID	NPI	PTAN

EDI Clearing House

EDI Clearing House	EDI Clearing House Website URL	Username	Password

Contracted Insurance Companies and Websites

Please provide the names of all insurance companies you contract with. IF you have website access please enter the URL and at least one username and password for ABC to check claim status, eligibility, and download EOBs. Please also indicate if you receive EFT or ERA from any insurance companies

Insurance Company	Insurance Website URL	Username	Password	EFT	ERA

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Insurance Company	Insurance Website URL	Username	Password	EFT	ERA

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Client Procedures

****Please answer the following questions as it pertains to your office****

1. What is the minimum balance you would like to send patient's a statement for?
2. Do you actively refund patients?
3. Do you have any capitated contracts?

****Please list all the IPA Names with capitated contracts****

4. Do you have a CLIA?
5. Do you bill secondary insurances as a courtesy?
6. Do you charge for no shows or same day cancellations?
   a. What is the fee?

7. What is your returned check fee?
8. Who at your office will approve patient accounts to be sent to collections?

9. Do you have a collection agency you would like to continue using?
10. Do you sell products, vitamins, supplements, or supplies?
    a. Will ABC be responsible for posting those charges and payments?

Hospital Affiliations

Please list the names of all hospitals and surgery centers your provider(s) are affiliated with

Provider Name	Hospital Name	Provider Name	Hospital Name

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Technical Information Worksheet

****Please fill out this form completely and email it to forms@advancedbillingconsultants.com or fax to 949.713.2931****

Client/Practice Name:

Technical Contact Name:

Technical Contact Phone #:

Technical Contact Email:

Will ABC be using Remote Desktop to access your preferred software?

Will ABC be using a VPN to access your preferred software?

Will you be accessing ABC's billing software?

Please list all EMR or Practice Management software we will need access to, as well as, all user names and passwords in the boxes provided below. If there are multiple logins, please list them below each other

Software	Version	Username	Password

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Remote Desktop Configuration (fill out if this applies)

Remote Desktop WAN IP:

Remote Desktop LAN IP:

Remote Desktop Port:

Remote Desktop Username	Remote Desktop Password

VPN Configuration (fill out if this applies)

What is the VPN for?

What is the make and model of the remote side's IPSEC VPN capable device?
(Device **MUST** support 3DES IPsec encryption or better)

VPN WAN IP:

VPN LAN IP Prefixes (i.e. 192.168.1.0/24):

Phase 1 Configuration Settings: (common default settings are in **bold,** but all listed settings are supported)

Supported Internet Key Exchange Mode (IKE)	**Main Mode**
Authentication pre-shared key	***Keys are exchanged verbally***
Supported Encryption (choose one)	**3DES** AES-128 AES-192 AES-256
Supported Secure Hash Algorithm (choose one)	MD5 **SHA-1** (SHA-1 is preferred)
Supported Key Exchange Protocol (choose one)	Diffle-Hellman Group **2** 5 7
Supported Key Lifetime in Seconds (choose one)	14400 **28800** 86400 Other:

Phase 2 Configuration Settings:

Supported Tunneling Protocol	**ESP**
Supported Encryption (choose one)	**3DES** AES-128 AES-192 AES-256
Supported Secure Hash Algorithm (choose one)	MD5 **SHA-1** (SHA-1 is preferred)
Perfect Forward Secrecy Enabled (choose one)	**YES** NO (if yes) Group: **2** 5 7
Supported Key Lifetime in Seconds (choose one)	14400 **28800** 86400 Other:

If you have any question about this information, please do not hesitate to call Brad at 949.713.3998 EXT: 115, or email brad@advancedbillingconsultants.com

Railroad Medicare
Electronic Data Interchange Application

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

Date: ____________________

Submitter ID: ____________________ ERN Receiver ID: ____________________

Submitter Name: ____________________

Owner 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: ____________________

Vendor ID (if applicable): ____________________

Provider For Whom Submitter Will Be Transmitting:

Provider Name: ____________________

Provider E-mail Address: ____________________

Provider Number: ____________________ NPI: ____________________

Enrollment Attached? ☐ Yes ☐ No

☐ Submit Claims ☐ Receive Electronic Remittances ☐ Receive Reports

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

Palmetto GBA EDI Operations
PO Box 10066
Augusta, GA 30999-0001

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

This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS) and American National Standard Institute (ANSI). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

MEDICARE ELECTRONIC DATA INTERCHANGE ENROLLMENT AGREEMENT

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers, MACs, or FIs:

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 carriers, MAC s, FIs, 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 health insurance claim number
   - Date(s) of service
   - Diagnosis/nature of illness
   - Procedure/service performed
5. That the Secretary of Health and Human Services or his/her designee and/or the carrier, MAC FI, 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 carrier, MAC, FI, 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.

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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 carrier, MAC, FI, 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 carrier, MAC, or FI (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 carrier, MAC, FI, 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 FI/carrier/ MAC 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 carrier, MAC, FI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, MAC, or FI or from any subsidiary of the carrier, MAC, FI, other contractor if designated by CMS, or from any company for which the carrier, MAC, or FI has an interest. The carrier, MAC, FI, 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 carriers, MACs, FIs, 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 carrier, MAC, FI, 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 the carrier, MAC, FI, 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.

This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS) and American National Standard Institute (ANSI). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

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.

Provider/Supplier Name: ____

Address: ____

____

City/State/ZIP: ____

Phone: ____

Authorized Signature: ____

By (Print Name): ____

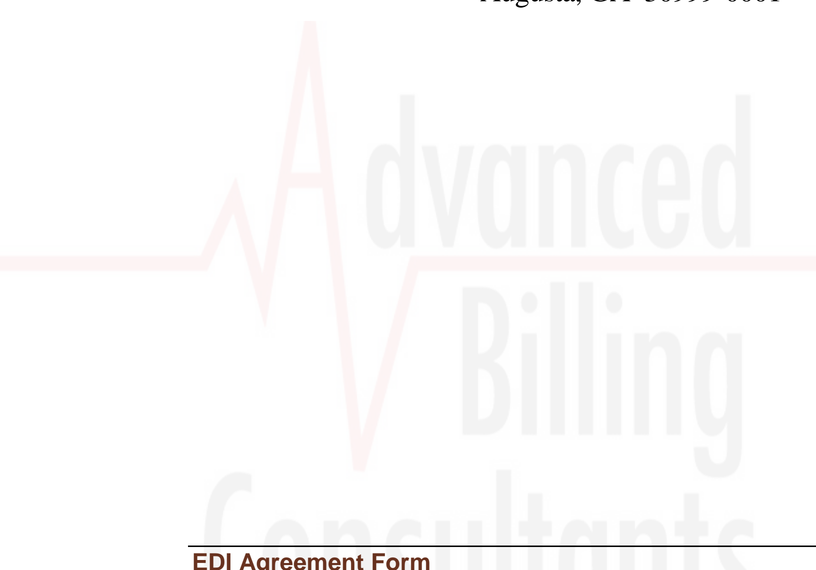
Title: ____

Date: ____________________ Medicare Provider Number ______________________

National Provider Identifier (NPI) ____

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

Palmetto GBA EDI Operations
P O Box 10066
Augusta, GA 30999-0001



This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS) and American National Standard Institute (ANSI). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

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: ____________________

Provider E-mail Address: ____________________

Provider Number: ____________________ NPI: ____________________

Name: ____________________

Title: ____________________

Address: ____________________

____

City: ____________________ State: ________ ZIP: ____________

Phone: ____________________

Submitter Name: ____________________

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 return this form, with the EDI Application Form, to:

Palmetto GBA EDI Operations
PO Box 10066
Augusta, GA 30999-0001

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This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS) and American National Standard Institute (ANSI). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

MEDI-CAL TELECOMMUNICATIONS PROVIDER AND BILLER APPLICATION/AGREEMENT
(For electronic claim submission)

1.0 IDENTIFICATION OF PARTIES

This agreement is between the State of California, Department of Health Care Services, hereinafter referred to as the "Department," and:

PROVIDER INFORMATION

Provider name (full legal)	Provider number		
DBA (if applicable)	Last 4 digits of Tax Identification Number or Social Security Number:		
Provider service address (number, street)	City	State	ZIP code
Contact person	E-mail address		
Contact person address (number, street)	City	State	ZIP code
Contact telephone number ( )	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number) N/A		

BILLER INFORMATION (If other than the provider of service)

Biller name (full legal) Jeff Newlin	Biller telephone number (702) 952-9993		
DBA (if applicable) Lightspeed Systems	E-mail address jeff@box49.com		
Business address (number, street) 4890 Appaloosa	City Angels Camp	State CA	Zip code 95222
Contact person Jeff Newlin	Currently assigned submitter number (otherwise, leave blank to be assigned a new submitter number) 4SK		

Full legal name(s) required as well as any assumed (DBA) name(s), address(es), and Medi-Cal provider number(s). The parties identified above will be hereinafter referred to as the "Provider" and/or "Biller."

1.1 CMC Batch Submission Type:

- ☐ Dial-up
- ☐ Magnetic tape
- ☒ Internet*

Real Time Submission Type:

- ☐ Point of Service (POS) ☐ Leased Line *or* ☐ Dial-up
- ☐ Internet*

* Note: Requires a completed network agreement on file.

INDICATE CLAIM TYPES WHICH WILL BE SUBMITTED ELECTRONICALLY

NCPDP Version (indicate version): ______

- ☐ Pharmacy (01)

ANSI X 12 837 Version (indicate version): 4010A1

- ☐ Long-Term Care (02)
- ☐ Inpatient (03)
- ☐ Outpatient (04)
- ☒ Medical/Allied Health (05)
- ☐ Vision (05)
- ☐ CHDP (11)
- ☐ Medicare Crossover Part A
- ☐ Medicare Crossover Part B

ANSI X 12 276/277 Version (indicate version): 4010A1

- ☐ Claim Status Inquiry/Response

ANSI X 12 278 Version (indicate version): ______

- ☐ Health Care Services and Review

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1.2 BACKGROUND INFORMATION

The Provider/Biller agrees to provide the Department with the above information requested in order to verify qualifications to act as a Medi-Cal electronic Biller.

2.0 DEFINITIONS

The terms used in this agreement shall have their ordinary meaning, except those terms defined in regulations, Title 22, California Code of Regulations, Section 51502.1, shall have the meaning ascribed to them by that regulation as from time to time amended. The term "electronic" or "electronically," when used to describe a form of claims submission, shall mean any claim submitted through any electronic means such as: magnetic tape or modem communications.

3.0 CLAIMS ACCEPTANCE AND PROCESSING

The Department agrees to accept from the enrolled Provider/Biller, electronic claims submitted to the Medi-Cal fiscal intermediary in accordance with the Medi-Cal provider manuals. The Provider hereby acknowledges that he has received, read, and understands the provider manual and its contents, and agrees to read and comply with all provider manual updates and provider bulletins relating to electronic billing.

3.1 CLAIMS CERTIFICATION

The Provider agrees and shall certify under penalty of perjury that all claims for services submitted electronically have been personally provided to the patient by the Provider or under his direction by another person eligible under the Medi-Cal Program to provide to such services, and such person(s) are designated on the claim. The services were, to the best of the Provider's knowledge, medically indicated and necessary to the health of the patient. The Provider shall also certify that all information submitted electronically is accurate and complete. The Provider understands that payment of these claims will be from federal and/or state funds, and that any falsification or concealment of a material fact may be prosecuted under federal and/or state laws. The Provider/Biller agrees to keep for a minimum period of three years from the date of service an electronic archive of all records necessary to fully disclose the extent of services furnished to the patient. A printed representation of those records shall be produced upon request of the Department during that period of time. The Provider/Biller agrees to furnish these records and any information regarding payments claimed for providing the services, on request, within the State of California to the California Department of HealthCare Services; California Department of Justice; Office of the State Controller; U.S. Department of Health and Human Services; or their duly authorized representatives. The Provider also agrees that medical care services are offered and provided without discrimination based on race, religion, color, national or ethnic origin, sex, age, or physical or mental disability. The Provider/Biller agrees that using his Medi-Cal Submitter ID plus DHCS-issued password when submitting an electronic claim will identify the submitter and shall serve as acceptance to the terms and conditions of the Department's Telecommunications Provider and Biller Application/Agreement (DHCS 6153), paragraph 3.0. The Provider/Biller further acknowledges the necessity of maintaining the privacy of the DHCS-issued password and agrees to bear full responsibility for use or misuse of the Medi-Cal Submitter ID and password should privacy not be maintained.

3.2 VERIFICATION OF CLAIMS WITH SOURCE DOCUMENTS

Regardless of whether the Provider employs a Biller, the Provider agrees to retain personal responsibility for the development, transcription, data entry, and transmittal of all claim information for payment. This includes usual and customary charges for services rendered. The Provider shall also assume personal responsibility for verification of submitted claims with source documents. The Provider/Biller agrees that no claim shall be submitted until the required source documentation is completed and made readily retrievable in accordance with Medi-Cal statutes and regulations. Failure to make, maintain, or produce source documents shall be cause for immediate suspension of electronic billing privileges.

3.3 ACCURACY AND CORRECTION OF CLAIMS OR PAYMENTS

The Provider agrees to be responsible for the review and verification of the accuracy of claims payment information promptly upon the receipt of any payment. The Provider agrees to seek correction of any claim errors through the appropriate processes as designated by the Department or its fiscal intermediary including, but not limited to, the process set out in Title 22, California Code of Regulations, Section 51015 and, as from time to time amended. The Provider/Biller acknowledges that anyone who misrepresents or falsifies or causes to be misrepresented (or falsified) any records or other information relating to that claim may be subject to legal action, including, but not limited to, criminal prosecution, action for civil money penalties, administrative action to recover the funds, and decertification of the Provider/Biller from participation in the Medi-Cal program and/or electronic billing.

4.0 CHANGE IN ELECTRONIC BILLING STATUS

The Provider/Biller and the Department agree that any changes in Provider/Biller status which might affect eligibility to participate in electronic billing pursuant to federal and state law shall be promptly communicated to each party.

5.0 PROVIDER/BILLER REVIEWS

The Provider/Biller agrees that agents of the Department of Health Care Services, the Office of the State Controller, the Department of Justice, or any other authorized agent or representative of the State of California or any authorized representative of the U.S. Department of Health and Human Services may, from time to time, conduct such reviews as are necessary to ensure compliance with state and federal law and with this agreement. In particular, the Provider/Biller agrees to make available to such agent or representative all source documents necessary to verify the accuracy and completeness of claims submitted electronically.

5.1 NONEXCLUSIVE REVIEWS

The Provider/Biller agrees that the review set out in paragraph 5.0 above is not exclusive but supplements any other form of audit or review the Provider/Biller may be subject to due to its status as a certified Provider/Biller of services under the Medi-Cal or Medicare programs.

6.0 EFFECTIVE DATE

This agreement shall become effective upon approval of the Department.

6.1 TERMINATION

The Department or Provider may terminate this agreement with or without cause by giving 30 days prior written notice of intent to terminate, and the Provider has no right to appeal such termination by the Department. The Department may, however, terminate this agreement immediately, pursuant to paragraph 6.2 upon determination that the Provider/Biller has failed or refused to produce or retain source documents in accordance with federal and state law or this agreement.

6.2 TERMINATION FOR CAUSE

If the Provider/Biller is unable to produce source documents on request pursuant to paragraph 5.0, the Department may terminate this agreement immediately by directing its fiscal intermediary to cease payment of any and all electronic claims submitted by the Provider/Biller, including any claims in process on the date of such termination. The Provider/Biller has no right to appeal termination for cause pursuant to this subpart prior to the effective date of such termination. The Provider/Biller may appeal any grievance resulting from the termination in accordance with the procedure established by Title 22, California Code of Regulations, Section 51015, as from time to time amended. The Department may demand repayment of claims for which no source documents are produced, and the Provider/Biller shall have a right to appeal of such an overpayment finding to the extent provided by Section 14171 of the Welfare and Institutions Code and regulations promulgated pursuant thereto, and as from time to time amended.

6.3 EFFECT OF TERMINATION AND APPEAL

On termination pursuant to paragraph 6.1 or 6.2, the Provider/Biller may submit hard copy claims.

7.0 AGREEMENT BETWEEN PROVIDER AND BILLER (IF OTHER THAN THE PROVIDER OF SERVICE)

The Provider stipulates that any agreements with Billers to submit Medi-Cal electronic billings shall be in conformance with state law governing electronic claims submission, and shall contain provisions including, but not limited to, the following:

a. The Provider shall specifically designate the Biller as the agent to the Provider for the purpose of preparation and submission of Medi-Cal claims by the Biller. As the Provider's agent, the Biller agrees to comply with all Medi-Cal requirements on recordmaking and retention as established by statute and regulation including, but not limited to, Welfare and Institutions Code, Sections 14124.1 and 14124 and Title 22, California Code of Regulations, Section 51476.

b. Electronic billing for services rendered to Medi-Cal beneficiaries shall be prepared by the Biller solely from information supplied by the Provider. This information includes usual and customary charges for services rendered. A printed representation of source documents as defined in Title 22, California Code of Regulations, Section 51502.1 shall be kept, including all information transmitted as a claim by the Provider to the Biller electronically, or a period of at least three years from the date of claims submission.

c. If a department audit is initiated, the Billing Service shall retain all original records described in paragraphs 3.2, 5.0, and 7.0(b) above until the audit is completed and every audit issue has been resolved, even if the retention period extends beyond three years from the date of the service of termination of financial relationship or longer period required by federal or state law.

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d. The parties shall agree that the Department may accept electronic billings prepared, certified, and submitted by the Biller on behalf of the Provider only as long as the agreement between the Provider and the Biller remains in existence and in effect.

e. Both parties have a duty to notify the Department in writing immediately upon any change in or termination of their agreement.

8.0 DECLARATION OF INTENT

This agreement is not intended as a limitation on the duties of the parties under the Medi-Cal Act, but rather as a means of clarifying those duties as they relate to the Provider/Biller in its capacity as an authorized Provider/Biller for electronic billing.

8.1 PROVIDER TO HOLD STATE OF CALIFORNIA HARMLESS

The Provider agrees to hold the State of California harmless for any and all failures to perform by billing services, billing software, or other features of electronic billing which do not occur with (hard copy) paper billing. The Provider explicitly agrees that the Provider is assuming any and all risks that accompany electronic billing and that the Provider is not relying upon the evaluation, if any, that the State has made of the electronic billing system, software, or Biller the Provider is using. Furthermore, the Provider acknowledges that if the electronic billing system, software, or Biller contracted with, is or has been listed as available in Medi-Cal bulletins, that such listing was not an endorsement by the State of California nor does it imply that the service, system, or software has met or is continuing to meet a standard of performance.

9.0 CONFIDENTIALITY OF RECORD

The Provider/Biller agrees to provide adequate precautions to protect the confidentiality of Medi-Cal beneficiary record and claims submission methods in accordance with statute or regulations Title 17, CCR, Section 6800, et seq. and/or 42 CFR, Part 400 and 440, Subpart B.

PROVIDER SIGNATURE INFORMATION

Full printed name	Title

Provider signature (original signature required; *DO NOT use black ink*)	Date

BILLING SERVICE SIGNATURE INFORMATION (complete only if "Biller Information" is completed on page 1 of 4)

Full printed name	Title
Jeff Newlin	Owner

Owner or Corporate Officer signature (original signature required; *DO NOT use black ink*)	Date

Return Application/Agreement to: EDS Corporation
CMC Unit
P.O. Box 15508
Sacramento, CA 95852-1508

Privacy Statement (Civil Code Section 1798 et seq.)

The information requested on this form is required by the Department of Health Care Services for purposes of identification and document processing. Furnishing the information requested on this form is mandatory. Failure to provide the mandatory information may result in your request being delayed or not be processed.

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Jurisdiction 1
Electronic Data Interchange Application

Line of Business Information: ☐ Part A ☒ Part B

☒ CA ☐ NV ☐ HI *(Note: Includes Samoa, Guam and Northern Mariana Islands)*

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

Submitter ID (if available): 000500323 **Date:** 12-10-2009

PPTN ID: **DDE ID:**

Submitter Name: Lightspeed/Transmedic

Owner Name: Jeff Newlin

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

EDI Contact Person: Jeff Newlin

Phone: 702-952-9993 **Fax:** 509-691-9907

Address: 4890 Appaloosa

City: Angels Camp **State:** CA **ZIP:** 95222

Submitter E-mail Address: jeff@box49.com

Note: E-mail will be the primary method of communication.

Claim Submission Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT: Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report / Electronic Remittance Retrieval Mode of Communication:	☒ GPNet Asynchronous ☐ CONNECT: Direct (NDM)	☐ Dial-up FTP ☐ Leased FTP
Report Response Format:	☒ File	☐ Report
Data Compression:	☒ Uncompressed (GPNet Default) ☐ PKZIP	☐ UNIX-Compress
Name of Software Vendor: Lightspeed/Transmedic		**Vendor Security ID:**
Online Inquiry Connectivity Vendor:	☐ IVANS ☐ VisionShare	☐ Other:

Providers for Whom Submitter Will Be Transmitting:

Provider Name:

Provider E-mail Address:

Provider Number: **NPI:**

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

☒ Submit Claims ☒ Receive Reports ☐ Receive Electronic Remittances ☐ Online Inquiry Services

Submit completed form to:

Palmetto GBA
J1 EDI Operations, AG-420
PO Box 100145
Columbia SC 29202-3145

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

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Medicare Electronic Data Interchange Enrollment Agreement

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' carriers, MACs, or FIs:

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 carriers, MACs, FIs 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 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 carrier, MAC, FI 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 carrier, MAC, FI or other contractor if designated by CMS;

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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 carrier, MAC or FI 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 carrier, MAC or FI (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 carrier, MAC or FI 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 FI/carrier/MAC 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, MAC, FI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the carrier, MAC, or FI, or from any subsidiary of the carrier, MAC, FI, other contractor if designated by CMS, or from any company for which the carrier, MAC, or FI has an interest. The carrier, MAC, FI, 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 carriers, MACs, FIs, 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 carrier, MAC, FI, 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;

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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 carrier, MAC, FI, 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 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.

Provider's Name: ____

Address: ____

____

City/State/Zip: ____

Phone: ____

Authorized Signature: ____

By (Print Name): ____

Title: ____

Date: ________________ Medicare Provider Number ______________________

National Provider Identifier (NPI): ______________________________

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

Palmetto GBA
J1 EDI Operations, AG-420
PO Box 100145
Columbia SC 29202-3145

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Jurisdiction 1
Provider Authorization Form

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

Line of Business Information: ☐ Part A ☒ Part B

Action Requested: ☒ Electronic Claims Submissions ☐ Electronic Remittance
☒ Electronic Response Reports ☐ Online Inquiry Services (PPTN or DDE)

Provider for whom Submitter will be granted access:

Provider Name: ______________________________

Provider E-mail Address: ______________________________

Provider Number: ________________ **NPI:** ________________

Name: ______________________________

Title: ______________________________

Address: ______________________________

____

City: ________________ **State:** ______ **ZIP:** ________

Phone: ______________________________

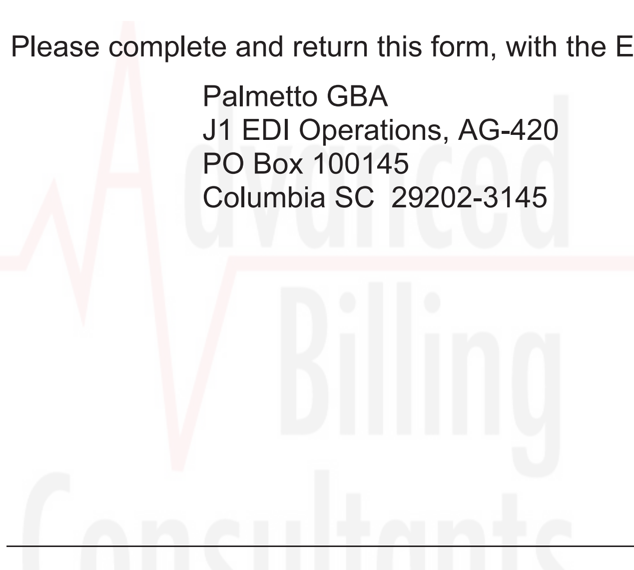
Submitter Name: Lightspeed/Transmedic

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 EDI in writing if I wish to revoke this authorization.

Signature ______________________________ **Date:** ________________

Please complete and return this form, with the EDI Application Form, to:

Palmetto GBA
J1 EDI Operations, AG-420
PO Box 100145
Columbia SC 29202-3145



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