



**MEDICARE
Electronic Data Interchange**

**General Completion Instructions
New Installation / Change of Vendor Form**

Congratulations on your decision to transmit claims electronically. To begin the process of electronic transactions, you will need a sender/submitter number, mailbox number and password. You will receive this information once this form has been processed. Please note, as with all EDI transactions, the provider must have a signed EDI Enrollment form on file with Medicare prior to electronic submission.

Note: If you are applying for the PC-ACE Pro32® Software, you are required to complete the PC-ACE Pro32® Software Application Package. You will find this application package located on the Web site www.fcso.com. Select Medicare Electronic Services-Software-PC-ACE Pro32.

This form should be used in the situations listed below:

- Providers, Billing Services or Clearinghouses that want to begin submitting claims electronically.
- Existing electronic sender/submitters that are changing software support vendors.
- Existing sender/submitters wanting to add an additional Medicare line of business (FL Only).

Please review the following completion instructions carefully. Sections A1, A2 and B must always be completed. All fields within Sections B through F of this form are required unless otherwise indicated as optional. If all required information is not provided, the form will be returned to the applicant for the additional information.

SECTION A1: Application Type. Select one of the options. This section is required.

New Installation: Check here if this is a new application to submit claims electronically directly to Medicare. **Complete Sections A2, B, C, D, E and F.**

Change of Vendor: Check here if changing software support vendors/companies for electronic transactions. This section does not apply when using a third party biller then changing to submit directly to Medicare. **Complete Sections A2, B and C.**

Add additional line of business: Check here if you wish to add an additional Medicare line of business, Medicare Part A (FL Only) or Medicare Part B to your existing sender/submitter number. **Complete Sections A2, B, C, D, E and F.**

SECTION A2: Location Type. Select one of the options. This section is required.

Provider/Supplier/Facility: Indicate in this section if you are a provider, supplier or facility.

Billing Service or Clearinghouse: Indicate in this section if you are a billing service or clearinghouse. As a third party biller, you are required to have a Medicare client prior to requesting a sender/submitter number.

Other: An entity other than the types mentioned above.

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

Sender/Submitter Name: Indicate the name of the entity that will be submitting the claims electronically.

Tax ID or Social Security Number: Indicate the Tax Identification Number or Social Security Number of sender/submitter applying to transmit electronically to Medicare. If you are a billing service or clearinghouse, indicate the billing service's/clearinghouse's Tax Identification or Social Security Number, not the Medicare provider's. The provider's information will be asked for in Section F.

Mailing Address: The address of the sender/submitter location transmitting claims. Please include any suite, apartment numbers or post office box numbers as appropriate.

City/State/Zip: Indicate the city, state and zip of the above mailing address.

County (Optional): Indicate the county in which this organization resides.

Email (Optional): Provide the email address of the contact name in case of inquiries.

Contact Name: Indicate the name of the person to be contacted regarding this form.

Position/Title (Optional): Indicate the position/title of the contact person.

Telephone: Indicate telephone number for the contact person.

Fax Number (Optional): Indicate the fax number for the contact person.

If location currently files electronic claims, indicate sender/submitter number (Optional): Indicate the sender/submitter number used to submit electronic claims. If submitting a change of software support vendor, indicate existing sender/submitter number.

Comments (Optional): Indicate any special considerations or comments.

SECTION C: Vendor Information. Your software support vendor can assist with this section. All fields in this section are required unless otherwise indicated as optional.

Company Name: Indicate the name of the software support company providing electronic application support.

Mailing Address/City/State/Zip (Optional): Indicate the complete address of the software support company.

Contact Name (Optional): Indicate the contact name at the software support company.

Telephone/Fax Number/E-Mail Address (Optional): Indicate telephone number; fax number and e-mail address for contact person at your software support company.

Comments (Optional): Indicate, if any, special consideration or comments.

SECTION D: Line of Business. Indicate the line of business the applicant is applying for. This section is required.

Medicare A – Electronic claims must comply with the ASC X12N 837 Institutional Guide (004010X096A1) (FL ONLY)

Medicare B - Electronic claims must comply with the ASC X12N 837 Professional Guide (004010X098A1) (FL and CT)

(Florida Only) If you will be transmitting claims for both lines of business for Medicare A and Medicare B, please note this on the form. However, to be approved for both lines of business, you must have a Medicare Part A provider and a Medicare Part B provider to submit electronic claims. You will be issued the same sender/submitter number for both lines of business unless otherwise requested.

SECTION E: National Provider Identifier (NPI). This section is required.

List the Medicare billing provider's NPI that will be submitting electronic claims through this sender/submitter number. If the provider is a member of a group, please indicate the group's (organization's) NPI.

SECTION F: Signature/Effective Date/Title of Signature/Tax Identification Number or Social Security Number/Medicare Provider number (if known). This section is required.

The signature of the provider or authorized party for the provider is required. Please indicate the effective date and the title of the authorized party. Please indicate the Medicare billing provider's Tax Identification Number. If the Medicare provider does not have a Tax Identification Number, please provide the Medicare billing provider's Social Security Number. If the Medicare Provider Number is known, please provide it.

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 the third party to act on behalf of the provider for the indicated EDI transaction(s). In such cases the provider is required to have on file, an agreement signed by that 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.**

Attention: The sender/submitter is required to notify Medicare EDI in writing in advance of any changes impacting their use of EDI and the effective date of such change. Medicare EDI must be notified if the provider will begin, change, or discontinue using a billing service, clearinghouse, or other third party, as well as of any changes related to electronic transactions the provider uses. The forms necessary to notify us of such changes can be downloaded from the Web site www.fcso.com. Select Medicare Electronic Services-Using EDI-Forms.



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New Installation / Change of Vendor Form

If you need assistance with this form, please refer to the "General Completion Instructions".

SECTION A1: APPLICATION TYPE. Select one of the following options. This section is required.

- New Installation. Completion of Sections A2, B, C, D, E and F is required.
- Change of Vendor. Completion of Sections A2, B and C is required.
- Add a Line of Business. Completion of Sections A2, B, C, D, E, and F is required.

SECTION A2: SENDER / SUBMITTER TYPE. Select one of the following options. This section is required.

- Provider
- Billing Service
- Clearinghouse
- Other (please specify) _____

SECTION B: SENDER/SUBMITTER LOCATION INFORMATION. All fields in this section are required unless otherwise indicated as optional.

Sender Name: _____

Tax ID or SS Number: _____

Mailing Address: _____

City/State/Zip: _____

County (Optional): _____ Email (Optional): _____

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

Telephone: _____ Fax (Optional): _____

If location currently files electronic claims, indicate sender/submitter (Optional): _____

Comment(s) (Optional): _____

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

Software Company Name: _____

Mailing Address (Optional): _____

City/State/Zip (Optional): _____

Contact Name (Optional): _____

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

Email address (Optional): _____

SECTION D: LINE OF BUSINESS. Indicate which line of business the applicant is applying for. This section is required.

_____ Medicare A - Electronic claims must comply with the ASC X12N 837 Institutional Guide (004010X096A1) (FL ONLY)

_____ Medicare B - Electronic claims must comply with the ASC X12N 837 Professional Guide (004010X098A1) (FL and CT)

SECTION E: NATIONAL PROVIDER IDENTIFIER (NPI) This section is required.

List the Medicare billing provider's NPI. If the provider is a member of a group, please indicate the group's (organization's) NPI.

| NPI | Billing Provider Name |
|------------|------------------------------|
| _____ | _____ |

SECTION F: SIGNATURE/EFFECTIVE DATE/TAX IDENTIFICATION NUMBER OR SOCIAL SECURITY NUMBER. This section is required.

The signature of the provider or authorized party for the provider is required. Please indicate the effective date and the title of the authorized party. Please indicate the Medicare provider's Tax Identification Number. If the Medicare Provider does not have a Tax Identification Number, please provide the Medicare provider's Social Security Number.

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 the third party to act on behalf of the provider for the indicated EDI transaction(s). In such cases the provider is required to have on file, an agreement signed by that 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.**

Print Name: _____

Signature: _____

Title: _____ Effective date: _____

Tax Identification Number or SSN of provider: _____

Medicare Provider Number (If known): _____

If a third party biller is applying for their own sender/submitter number, please have each provider client sign and date this section. For additional space, please copy this section and submit with this form.

NOTE: If the Medicare provider has an EDI Enrollment Form on file with Medicare EDI, no EDI Enrollment Form is required. However, if the provider does not have an EDI Enrollment Form on file, you are required to submit both the New Installation / Change of Vendor Form and the EDI Enrollment Form together.

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, as well as of any changes related to electronic transactions the provider uses. The forms necessary to notify us of such changes can be downloaded from the Web site www.fcso.com. Select Medicare Electronic Services-Using EDI-Forms.

FAX OR MAIL COMPLETED FORMS TO:

Mailing Address:

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

Telephone and Fax Numbers:

FL (904) 791-8767, option 2
CT (203) 639-3160, option 1
Fax (904) 791-6692

Physical Address:

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