



Electronic Data Interchange (EDI) Novitasphere Portal Enrollment



This form is for providers to complete for EDI enrollment to Novitasphere, Novitas Solutions' internet portal. All fields marked with * are required and must be completed or the request will be rejected.

General Information

R5-25

*Line of business:

*State:

Provider Information (Must match the name for the Group/Billing Provider on file with Medicare as reported on the CMS-855 Enrollment form)

| | |
|----------------------------|------------------------|
| *Provider name: | *Contact name: |
| *Contact telephone number: | Contact fax number: |
| *Street address: | *City: |
| *State/Province: | *Zip code/Postal code: |
| *Contact email address: | |

| Provider Identification | | |
|---------------------------------------------|--------------------------------------|-------------------------------------------------------------------------------------------|
| *Provider Transaction Access Number (PTAN): | *National Provider Identifier (NPI): | *Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN) |

For group providers, the PTAN/NPI provided MUST be the Group PTAN/NPI. PTANs may also be known as a CMS Certification Number. For Affiliated PTANs or National Provider Identifiers (NPIs), attach the [EDI Enrollment Affiliated Provider List](#), if needed.

Approver Information

This section is for organizations to designate the approver and backup approver. Individuals designated as approvers and backup approvers must register in IDM (Identity Management System) and access Novitasphere at least once every 30 days to maintain access once they receive approval from Novitas. Please review our instruction page for additional information on how to register ([JH](#)) ([JL](#)). I acknowledge that registration to the Identity Management (IDM) system is required. Instructions for IDM are available on our website ([JH](#)) ([JL](#)).

Note: Individual end user names should not be included on this form.

| | | |
|------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|------------------------|
| <i>This will be the User ID's First and Last Name when completing the IDM registration for the Provider Office Approver role</i> | | |
| *Approver first name: | *Approver last name: | *Approver email: |
| <i>This will be the User ID's First and Last Name when completing the IDM registration for the Provider Office Back-Up Approver role</i> | | |
| Backup approver first name: | Backup approver last name: | Backup approver email: |

PC-ACE

***Required: Select one** Yes, enroll for PC-ACE No, do not enroll for PC-ACE I already have PC-ACE

PC-ACE Enrollment is only needed if your office will be using the PC-ACE software to create claim files.

When selecting to enroll, you are agreeing to the software terms listed below.

- Novitas Solutions is authorized to distribute PC-ACE/PRINTLINK/ETRA (herein referred to as the "Program") to authorized users. PC-ACE and PRINTLINK software programs are copyrights of ABILITY. The Program is distributed for the purpose of creating electronic Medicare claim files only. Any use not authorized herein is strictly prohibited, including but not limited to, making copies of any part of the Program, reselling, or transferring copies to any party, or creating any modified or derivative work.
- The Program is provided "as is" without warranty of any kind, either expressed or implied, including but not limited to the implied warranties of merchantability or fitness for particular purpose.
- In no event will Novitas Solutions be liable for any loss or damage, including but not limited to incidental or consequential damages, arising out of the use or inability to use the Program even if Novitas Solutions has been advised of the possibility of such damages, or for any claim by any other party.
- The authorized user will upgrade this Program within 90 days of upgrade availability. This is a CMS requirement.
- The authorized user will provide the necessary office space, all electrical and telephone connections, hardware, telecommunication software and equipment that adhere to the technical requirements located on our website ([JH](#)) ([JL](#)).
- Internet download is the preferred method of software installation. Internet download instructions will be provided upon processing of this enrollment. There is no fee for software installation via Internet download. To receive the Program in CD-ROM format, visit our website ([JH](#)) ([JL](#)) for ordering instructions. A non-refundable \$100 annual service fee is required. This service fee covers four quarterly PC-ACE releases.

Agreement

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS A/B MACs or CEDI:

The Provider Agrees:

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 A/B MACs, DME MACs or CEDI 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 Medicare beneficiary identifier, 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 A/B MAC, DME MAC, CEDI 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 A/B MAC, CEDI, 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.
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 A/B MAC, DME MAC, CEDI, 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 A/B MAC, DME MAC, or CEDI (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 A/B MAC, CEDI or other contractor if designated by CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

The Centers for Medicare & Medicaid Services (CMS) agrees to:

1. Transmit to the provider an acknowledgement of claim receipt.
2. Affix the A/B MAC, CEDI 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 A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the A/B MAC, CEDI or from any subsidiary of the A/B MAC, CEDI, other contractor if designated by CMS, or from any company for which the A/B MAC, CEDI has an interest. The A/B MAC, CEDI, 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 A/B MACs, CEDI, or other contractor 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 sold directly, indirectly, or by arrangement by the A/B MAC, CEDI, or other contractor if designated by CMS.
6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:

Federal law and applicable regulation and guidance, including IOM Pub. 100-04, Chapter 24, Section 30.2, 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/Section 1011 claims or any other EDI transactions are submitted to CMS or the CMS contractor. Either party may terminate this arrangement by giving the other party thirty (30) days written notice of its intent to terminate, except as noted in applicable regulation and guidance, including IOM Pub. 100-04, Chapter 24, Section 30.2. 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.

If Providers elect to submit/receive transactions electronically using a third party such as a billing agent or a clearinghouse, the A/B MACs or CEDI must notify these providers that they are required to have an agreement signed by that third party. The third party must agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. (These agreements are not to be submitted to Medicare but are to be retained by the providers.)

Attestation

Any provider who submits Medicare claims electronically to CMS or its contractors remains responsible for those claims as those responsibilities are outlined on the EDI Enrollment. In accepting claims submitted electronically to the Medicare Program from any billing service or through the use of a particular product which accomplishes this process, neither CMS, nor any other Medicare contractors are attesting to the appropriateness of the methods used by the billing service/clearinghouse or to the accuracy of a particular vendor's product used to facilitate such electronic submissions. The provider furnishing the item or service for whom payment is claimed under the Medicare Program retains the responsibility for any claim regardless of the format it chooses to use to submit the claim.

Prior to signing this agreement, please carefully review the technical requirements for electronic billing in Chapter 2 of the Electronic Billing Guide ([JH](#)) ([JL](#)).

I understand that any individual who knowingly and willfully makes or causes to be made any false claim or false statement of false representation of a material fact in any application to the federal government for benefits or payment with respect to the Medicare program may be subject to civil and/or criminal enforcement action which may result in fines, penalties, damages and/or imprisonment.

Authorized Official Signature Requirements

By signing below, I certify that I have been appointed an authorized official to whom the provider has granted the legal authority to enroll it in the Medicare Program, to make changes and/or updates to the provider's status in the Medicare Program (e.g., new practice locations, change of address, etc.), and to commit the provider to abide by the laws, regulations, and the program instructions of Medicare. I authorize the above listed entities to communicate electronically with Novitas on my behalf.

By signing below the provider confirms they have read and agree with the provider EDI agreement, the CMS' obligations, and the attestation sections of this document and above signature requirements.

***The Authorized Official signing this form should be an AUTHORIZED OR DELEGATED OFFICIAL that was listed on the Medicare Enrollment Application (CMS-855). Clearinghouse and Billing Service representatives are not permitted to sign for the provider.**

Required Signature

***Required: Complete ALL signature information**

| | |
|------------------------------------------------------------------------------------|-------------------------------------------------|
| *Written Signature of Person Submitting Enrollment (add after you print the form): | *Date (mm/dd/yyyy): |
| *Printed Name of Person Submitting Enrollment: | *Printed Title of Person Submitting Enrollment: |

Complete form, print, sign, date, and fax (recommended), OR mail all pages to:

JH: Novitas Solutions, Inc. - EDI - PO Box 3093, Mechanicsburg, PA 17055-1811

JL: Novitas Solutions, Inc. - EDI - PO Box 3011, Mechanicsburg, PA 17055-1801

OR Fax: 1 (877) 439-5479

Allow two weeks for processing. Please do not send duplicate forms.

Reference Materials

Carefully review the block-by-block instructions for completing this form ([JH](#)) ([JL](#)).

To request the status of your EDI enrollment form, complete the EDI Enrollment Status Inquiry Tool ([JH](#)) ([JL](#)).

For questions, please contact the Novitasphere Help Desk at 1-855-880-8424.