



## Electronic Data Interchange (EDI) Novitasphere Third Party Portal Enrollment



This option is for Billing Services or Clearinghouses that would like to have access to Medicare data via the internet. Please complete this form for enrollment to Novitasphere, Novitas Solutions' internet portal. Providers should not complete this form. Providers should complete the Novitasphere Enrollment Form (8292P).

All fields marked with \* are required and must be completed or the request will be rejected

*Third-Party Information				
*Legal business name:	*Nine-digit Tax ID or EIN:			
*Street address:		*City:		
*State:		*Zip Code:		
*Website Address:	Fax Number:			
The Tax ID must match the Tax ID en *Third-Party Contact Informa		the organizatio	n in the Identity Management	(IDM) system.
*Technical Contact Name/Department:	*Telephone:		*Email Address:	
*Marketing Contact:	*Telephone:		*Email Address:	
Note: An email may be sent to the Technical name, marketing contact phone number, and rendor List on the Novitas Solutions website	I marketing contact	email address		
	on EDI's websit			

## **Novitasphere Portal Information**

This option is not available to vendors. This option is for Billing Services or Clearinghouses that wish to have access to Medicare data via the Internet. Users are encouraged to attach the Migration List Template with this form to request the conversion of multiple Provider Transaction Access Numbers (PTANs) from their current submitter ID to their Novitasphere submitter ID, rather than requiring each provider to complete a Novitasphere Portal Enrollment form. You will be unable to log into Novitasphere until at least one provider is linked to your new submitter ID.

All Novitasphere Billing Service/Clearinghouse Portal submitter ID's will be set up with the ability to submit 837 claim files and receive 837 Electronic Remittance Advice through the portal.

By enrolling for Novitasphere, users agree to use an approved software, vendor (JH) (JL) for sending batch files.

Туре	of Request								
	choose your requequesting to send			_	ions), com	plete the d	ental claim	block below.	
	Assign a new N I am a Billing Se If nothing or both are s A billing service collect	ervice selected, submi	or Clea	ringhouse tup as a billing	service.	c claim files. A cl	learinghouse trai	nsfers EDI transactions	for the provider.
	I am currently u Other feature or	•	•	•	•		te box belo	W.	
Featu	res								
What fea	atures do you su	pport? Cl	ick all th	at apply:					
	Enroll for batch	claim statu	ıs (276/27	77 files).					
Dental	Claims								
Optiona	I: Only complete	this bloc	k if you a	are reques	sting 837D	dental cla	aim transa	ctions	
	Assign this third	party a ne	w/separa	te electron	ic Novitasp	here portal	submitter II	D for 837D claim	files.
	Add 837D to exi	sting Novi	tasphere	portal subn	nitter ID:				
	Assign 837D to	the new su	ıbmitter II	D being red	uested with	n this form.			
Contra	acts								
*What co	ontracts do you s	support?	Click on	ly those tl	hat curren	tly apply:			
	JH - Arkaı	nsas, Colora	ado, Louisi	ana, Mississ	ippi, New Me	exico, Oklaho	oma, Texas, a	nd J04911	
Part	Assign sepa	rate subm	itter IDs p	er contract	: Separate su	bmitter IDs are	e required for F	Part A.	
Α	AR	СО	LA	MS	NM	OK	TX	J04911	
D = m4	Assign <b>c</b>	<b>ne</b> submit	ter ID for	all JH cont	racts. This is	the JH defaul	lt if both Part B	options are selected	l.
Part B	Assign <b>sep</b> a	<b>arate</b> subn	nitter IDs	per contrac	ot:				
D	AR	СО	LA	MS	NM	OK	TX		
	JL - Delaw	are, Marylaı	nd, New Je	rsey, Pennsy	ylvania, Wasl	hington D.C.	Metro Area, a	and J12901	
Part A	Assign sepa DC/MD	arate subm DE	nitter IDs p NJ	per contrac PA	t: Separate su J12901		re required for i	Part A.	
Dant	Assign o	ne submit	ter ID for	all JL cont	racts. This is	the JL default	if both Part B	options are selected.	
Part B	Assign <b>sep</b> a	arate subn	nitter IDs <sub>I</sub>	per contrac	et: PA				

## **Approver Designation**

Please designate the member(s) of your staff who should be the Billing Office Approver and Billing Office Back-Up Approver for your organization. We encourage you to select members of your staff who are knowledgeable and have tenure with the organization. **Do not complete this section with End User information**. End Users will request access through Identity Management (IDM).

I acknowledge that registration to the IDM system is required. Instructions for IDM registration will be included in your enrollment letter received upon completion of this enrollment request. Sharing of your IDM user ID will result in deactivation.

*Approver Designation	Contact Information	
*Billing Office Approver First Name:	*Billing Office Approver Last Name:	*Billing Office Approver Email Address:
Billing Office Back-Up Approver First Name:	Billing Office Back-Up Approver Last Name:	Billing Office Back-Up Approver Email Address:

The first and last names provided above must match the user's first and last names in the IDM registration for the corresponding roles. All email addresses on this form may be used for enrollment processing response.

## 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 uade 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, contact the EDI Help Desk
  to request the PC-ACE CD-ROM request form. A non-refundable \$100 annual service fee is required. This service fee covers four quarterly PCACE releases.

**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 third party agent. The responsibilities and obligations contained in this document will remain in effect as long as electronic data interchange is being conducted with an A/B MAC, DME MAC or CEDI. Either party may terminate this arrangement by giving the other party (30) days notice of its intent to terminate. In the event that the notice is mailed, 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.

**Signature:** The signatory hereto represents and warrants that he/she is duly authorized to sign, execute, and deliver this Agreement on behalf of the party it represents for the Medicare Program 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 Solutions on my behalf.

*Required Signature	
*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.