



Capario Enrollment  
1901 E. Alton Ave. #100  
Santa Ana, CA. 92705  
Phone: (800) 792-5256 Option 1  
Fax: (404) 877- 3324  
provider.enrollment@Capario.com

## Payer Agreement Instructions for Ohio Medicare (MR033) | West Virginia Medicare (MR056)

You will enroll by completing and sending the Payer Agreement directly to the Payer. In addition please complete and send the Capario Enrollment Request Form to our Capario EDI Enrollment Team. Specific instructions for this Payer are shown below.

If you are a Capario customer then complete the Payer enrollment process BEFORE submitting claims for to Capario for this Payer.

If you are not yet a Capario customer please contact Capario sales at: [ProviderSales@Capario.com](mailto:ProviderSales@Capario.com) or 800-586-6870.

### Guidelines for Enrolling with this Payer

1. Mail the **EDI Application and Enrollment Agreement** to:

Palmetto GBA  
Medicare Part B EDI  
P.O. Box 182934  
Columbus, OH 43218-2934

2. Fax or Mail the **Capario Enrollment Request Form** to:

Fax: (404) 877-3324  
Capario EDI Enrollment  
Capario  
1901 E. Alton Ave. Suite 100  
Santa Ana, CA. 92705

To obtain the Capario Enrollment Request Form, go to:  
[www.capario.com/services/resource\\_center/enrollment\\_instructions.html](http://www.capario.com/services/resource_center/enrollment_instructions.html)

*Questions? Contact Capario Enrollment at: (800) 792-5256 Option 1*

## 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  |
|--|--|
| <b>Action Requested:</b><br>Add New EDI Provider(s)<br>Change/Update<br>Delete<br>Apply for New Submitter ID | Indicate the action to be taken on the application form. <ul style="list-style-type: none"> <li>• If you need to add additional providers to an existing Submitter ID, check <b>Add New EDI Provider(s)</b>.</li> <li>• If you request to change/ update information about the Submitter, check <b>Change/Update</b> and be sure to include your current Submitter ID.</li> <li>• If you request to delete a provider(s), check <b>Delete</b> and be sure to include your submitter ID.</li> <li>• If you are a new applicant, check <b>Apply for New Submitter ID</b>.</li> </ul> |
| <b>Submitter ID</b>  | 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.   |
| <b>Date</b>  | Please enter the date the application is completed.  |
| <b>Submitter Name</b>  | Enter the name of the entity (provider, software vendor, billing service or clearinghouse) that will actually be communicating electronically with Palmetto GBA.   |
| <b>Type of Submitter</b>   | Check the appropriate box.   |
| <b>Contact Person</b>  | 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.   |
| <b>Phone</b>   | The area code and phone number of the Contact Person listed.   |
| <b>Fax</b>   | The Fax number of the Contact Person listed.   |
| <b>Address</b>   | The mailing address of the submitter.  |
| <b>City, State, Zip</b>  | The city, state, and zip code of the submitter.  |

| Form Field Name   | Instructions for Field Completion  |
|---|--|
| <b>E-mail Address</b>   | The Contact Person's e-mail address. <b>Note: This will be the primary method of communication.</b>  |
| <b>Claim Submission Mode of Communication</b>                             | There are three available modes of communication that can be used for claim submission: <b>Check only one.</b> <ul style="list-style-type: none"> <li>• <b>GPNet:</b> Asynchronous communication with the Gateway</li> <li>• <b>Connect Direct – NDM:</b> Network Data Mover</li> <li>• <b>Dial-up FTP:</b> File transfer protocol transmission via GPNet-not Internet</li> </ul>  |
| <b>Report/Electronic Remittance Retrieval Mode of Communication</b>       | Check <b>only one</b> mode of communication that will be used. <ul style="list-style-type: none"> <li>• <b>GPNet Asynchronous</b> should be checked for asynchronous communication with Palmetto GBA's GPNet.</li> <li>• <b>CONNECT:Direct (NDM)</b> should be checked for report retrieval via GPNet.</li> <li>• <b>Dial-up FTP</b> should be checked for file transfer protocol report retrieval via GPNet.</li> </ul> |
| <b>Request Response Format</b>  | Check the format in which you will receive GPNet Claim Acceptance Responses.   |
| <b>Data Compression</b>   | To receive files compressed for faster transmission, indicate which data compression utility you support.  |
| <b>Name of Software Vendor</b>  | Indicate the name of the software vendor you are using. If applicable.   |
| <b>Providers For Whom Submitter Will Be Communicating Electronically:</b> |  |
| <b>Provider Name</b>  | 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 <i>Multiple Providers List</i> form.)   |
| <b>Provider Number</b>  | Indicate the 7-character Group Medicare Provider Number or 7-character Solo Practice Medicare Provider Number for each provider listed.  |
| <b>NPI</b>  | Include the National Provider Identifier (NPI).  |
| <b>Enrollment Attached?</b>   | Indicate "Y" for Yes or "N" for No. A properly executed 3-page <b>EDI Enrollment Agreement</b> must be attached for <i>each</i> provider listed. <b>Palmetto GBA will not activate a submitter ID for any provider without a properly executed EDI Enrollment Agreement.</b>   |
| <b>Submit Claims</b>  | Check this box if the application is for the submitter to submit claims electronically for this provider.  |
| <b>Receive Electronic Remittances</b>                                     | 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.   |
| <b>Receive Reports:</b>   | 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: **Palmetto GBA**  
 Medicare Part B EDI  
 PO Box 182934  
 Columbus OH 43218-2934



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:             | <input checked="" type="checkbox"/> GPNet Asynchronous<br><input type="checkbox"/> Connect Direct: (NDM) | <input type="checkbox"/> Dial-up FTP |
| Report/Electronic Remittance Mode of Communication: | <input checked="" type="checkbox"/> GPNet Asynchronous<br><input type="checkbox"/> Connect Direct: (NDM) | <input type="checkbox"/> Dial-up FTP |
| Request Response Format:                            | <input checked="" type="checkbox"/> File <input type="checkbox"/> Report                                 |                                      |
| Data Compression                                    | <input type="checkbox"/> PKZIP <input type="checkbox"/> 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:

Palmetto GBA  
 Medicare Part B EDI  
 PO Box 182934  
 Columbus, OH 43218-2934

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



Ohio & West Virginia Part B  
Electronic Data Interchange Application

Multiple Providers List

Date: \_\_\_\_\_

**PROVIDERS FOR WHOM SUBMITTER WILL BE TRANSMITTING:**

|   |  |  |  |
|---|--|--|--|
| <b>Action Requested:</b> <input type="checkbox"/> Add Provider <input type="checkbox"/> Change <input type="checkbox"/> Delete Provider |  |  |  |
| <b>Provider Name:</b> _____   |  |  |  |
| <b>Provider Number:</b> _____   |  | <b>NPI:</b> _____  |  |
| <b>Enrollment Attached?</b> <input type="checkbox"/> Submit Claims  |  | <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Receive Reports |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| <b>Action Requested:</b> <input type="checkbox"/> Add Provider <input type="checkbox"/> Change <input type="checkbox"/> Delete Provider |  |  |  |
| <b>Provider Name:</b> _____   |  |  |  |
| <b>Provider Number:</b> _____   |  | <b>NPI:</b> _____  |  |
| <b>Enrollment Attached?</b> <input type="checkbox"/> Submit Claims  |  | <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Receive Reports |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| <b>Action Requested:</b> <input type="checkbox"/> Add Provider <input type="checkbox"/> Change <input type="checkbox"/> Delete Provider |  |  |  |
| <b>Provider Name:</b> _____   |  |  |  |
| <b>Provider Number:</b> _____   |  | <b>NPI:</b> _____  |  |
| <b>Enrollment Attached?</b> <input type="checkbox"/> Submit Claims  |  | <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Receive Reports |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| <b>Action Requested:</b> <input type="checkbox"/> Add Provider <input type="checkbox"/> Change <input type="checkbox"/> Delete Provider |  |  |  |
| <b>Provider Name:</b> _____   |  |  |  |
| <b>Provider Number:</b> _____   |  | <b>NPI:</b> _____  |  |
| <b>Enrollment Attached?</b> <input type="checkbox"/> Submit Claims  |  | <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Receive Reports |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| <b>Action Requested:</b> <input type="checkbox"/> Add Provider <input type="checkbox"/> Change <input type="checkbox"/> Delete Provider |  |  |  |
| <b>Provider Name:</b> _____   |  |  |  |
| <b>Provider Number:</b> _____   |  | <b>NPI:</b> _____  |  |
| <b>Enrollment Attached?</b> <input type="checkbox"/> Submit Claims  |  | <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Receive Reports |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |
| <b>Action Requested:</b> <input type="checkbox"/> Add Provider <input type="checkbox"/> Change <input type="checkbox"/> Delete Provider |  |  |  |
| <b>Provider Name:</b> _____   |  |  |  |
| <b>Provider Number:</b> _____   |  | <b>NPI:</b> _____  |  |
| <b>Enrollment Attached?</b> <input type="checkbox"/> Submit Claims  |  | <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Receive Reports |  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |  |

## EDI Enrollment Agreement Instructions

The following EDI Enrollment Agreement should be submitted when enrolling for electronic billing. It should be reviewed and signed only by the providers to ensure each provider is knowledgeable of the enrollment request and the associated requirements.

Providers that have contracted with a third party (clearinghouse/network service vendor or a billing agent) are required to have 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 the viewing or use of Medicare Beneficiary data. These agreements are not to be submitted to Medicare, but are to be retained by the providers.

Providers are obligated to notify Medicare by letter of:

- Any changes in their billing agent or clearinghouse.
- The effective date of which the provider will discontinue using a specific billing agent or clearinghouse.
- If the provider wants to begin to use additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouse begins to use alternate software, the clearinghouse is responsible for notification in this instance.

Note: The binding information in an EDI Enrollment Agreement does not expire if the person who signed the form for a provider is no longer employed by the provider.

### General Instructions

- Please ensure that you include your **Medicare Provider Number** (and National Provider Identifier [NPI]) where requested on the EDI Enrollment Agreement. **Do not** enter your TAX ID Number.
- If the submitter will be submitting for multiple providers, this form must be completed by *each* provider whose claim data will be submitted.
- The entire form must be read carefully, dated with day, month and year.
- The name of the provider must be printed in the space provided, an authorized officer's name (printed), authorized officer's title and signature.
- When completed, the properly executed **3-page EDI Enrollment Agreement** must be returned *with* the **EDI Application** form to the following address:

Palmetto GBA  
Medicare Part B EDI  
PO Box 182934  
Columbus, OH 43218-2934

Note: If the submitter will be an entity other than the provider, the submitter must complete the OH/WV Part B EDI Application form and the provider must complete the EDI Enrollment Agreement. The EDI Application form must be returned with the EDI Enrollment Agreement enclosed for each applicable provider.

**IMPORTANT NOTICE PLEASE READ**

**The address shown on the EDI Enrollment Agreement must match the address that was submitted to our Provider Enrollment Department when enrolling for a provider number. If the address on the completed EDI Enrollment Agreement *does not* match, your entire EDI Enrollment Packet will be returned.**

The **National Provider Identifier (NPI)** must be printed in the space provided on the EDI Enrollment Agreement. If this information is missing, the **EDI Enrollment Agreement will not be processed.**

## 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, 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
  - 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.

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.

**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 to:

Palmetto GBA  
Medicare Part B EDI  
PO Box 182934  
Columbus, OH 43218-2934