EDI Change Form Instructions

The change form is to be used to:
a) change trading partner or vendor information, OR
b) add additional provider numbers or transactions

Section 1
Trading Partner Information:

Organization Name	-	print name of the organization submitting files
Mailing Address	-	print the address of the organization
City, State, Zip	-	print the city, state and zip code of the organization
Telephone #	-	print telephone number of organization
Fax #	-	print fax number of organization
E-mail Address	-	print e-mail address of contact at the organization

Section 2
Vendor Information:

Software Company Name	-	print name of software company that supports your practice management software
Mailing Address	-	print address of software company
City, State, Zip	-	print city, state and zip code of software company
Contact Name(s)	-	print contact name(s) for the software company
Telephone #	-	print telephone number of software company
Fax #	-	print fax number of software company
E-mail Address	-	print e-mail address for software company

Section 3
Billing Provider Numbers:
Enter billing provider numbers or Provider Transaction Access Number (PTAN) and transactions not previously submitted.
NPI – 10-digit billing number

*****You must indicate the transaction to be added with the billing provider number or Provider Transaction Access Number (PTAN) , NPI , and provider name.*****

Completed forms can be faxed to:
Wheatlands Administrative Services
P.O. Box 3500
Topeka, KS. 66601-3500
Fax number: 785-290-0720

*****All pages of EDI enrollment form must be returned******

EDI Change of Information Form

This form is to be used to:
a) change trading partner or vendor information, OR
b) add additional provider numbers or transactions

To change trading partner contact information:
- e-mail new contact information to MedicareEDI@wheatlandsadmin.com (only if e-mail address contains name of facility) OR
- fax new contact information on company letterhead to 785-290-0720.

Section 1: Trading Partner Information

Trading Partner Number 0006634

Organization Name (legal name): PracticePRO Software Systems Inc.

Mailing Address: 390 5th Ave Suite 408

City: New York

State: NY **Zip:** 10018

Telephone #: (516 **)** 745-0888

Fax #: (212 **)** 244-2127

E-mail Address: edi@quickpractice.com

Section 2: Vendor Information

Software Company Name: PracticePRO Software Systems Inc.

Mailing Address: 390 5th Ave Suite 408

City: New York

State: NY **Zip:** 10018

Contact Name: EL YOUBI, Fahd

Telephone #: (516 **)** 745-0888

Fax: (212 **)** 244-2127

E-mail Address: edi@quickpractice.com

Section 3: Billing Provider Numbers/NPI and available transactions

Select the appropriate transaction for the billing provider number or NPI you are enrolling.

Professional Provider(s)			
Payer	**Payer Provider Number or PTAN Number**	**NPI**	**Provider Name**
Medicare B (KS, NE, NWMO): ☑ 837P(professional claims) ☐ 276/277 (claims status)			
Institutional Providers			
Medicare A (KS): ☐ 837I (institutional claims) ☐ 276/277 (claims status)			

General Information

Please provide in writing to Wheatlands Administrative Services any future changes to the information contained in this EDI setup form within 5 business days of the change.

Wheatlands Administrative Services will make every attempt to give 60 days notices of any material changes to the EDI system that may effect trading partners data transmissions. Updates to any system changes will be made through the e-mail list notification on the Wheatlands Administrative Services Web site. Trading partners are responsible for signing up for the e-mail list notifications.
In an effort to keep our records up to date, provider numbers with no activity for at least six months will be removed from a trading partner number. Once removed from a trading partner number, the EDI enrollment form will need to be completed to re-add this number.

Kansas law applies to this business relationship.

Completed forms may be sent to:
Wheatlands Administrative Services
P.O. Box 3500
Topeka, KS 66601-3500
Fax number: 785-290-0720

*****All pages must be returned*****

MEDICARE AGREEMENT

ELECTRONIC DATA INTERCHANGE (EDI) ENROLLMENT FORM

The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS contractors.

A. The Provider Agrees:

1. That it will be responsible for all Medicare claims submitted to CMS 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 contractors, without the express written permission of the Medicare beneficiary and/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 contractor 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 documents 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 of the provider on each claim electronically transmitted to the contractor.

10. That the CMS-assigned unique identifier number 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 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 contractor, shall not be used by agents, officers, or employees of the billing service except as provided by the contractor (in accordance with §1106(a) of the Act).

14. That it will research and correct claim discrepancies.

15. That it will notify the contractor or CMS within 2 business days if any transmitted data are received in an unintelligible or garbled form.

B. CMS Agrees To:

1. Transmit to the provider an acknowledgement of claim receipt.

2. Affix the intermediary/carrier 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 contractor may require the provider to purchase any or all electronic services from the contractor or from any subsidiary of the contractor or from any company for which the contractor has an interest. The contractor 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 contractors 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 contractor sells directly, indirectly, or by arrangement.

6. Notify the provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

NOTICE:
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 contractor. Either party may terminate the Agreement 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. Signatures:

I am authorized to enter into this Agreement on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

PLEASE COMPLETE ENTIRE FORM - ALL FIELDS ARE REQUIRED

Billing Provider # or Provider Transaction Access Number (PTAN):
National Provider Identifier:
*Provider Name and Title:
Practice Name:
Contact Name and Title:
*Provider Address, City/State/ZIP:
*Original Signature: ***X***
*Print Name of signer and title:
*Date: