Submit the completed form to:
ABILITY Network, ATTN: Enrollment
FAX: 888.837.2232 | EMAIL: setup@abilitynetwork.com

INSTRUCTIONS

• Please type provider information on enrollment forms for ease of processing.

• Medicare requires providers who submit claims as a group to complete the EDI enrollment documentation with the group name, group NPI, and group PTAN.

• If you do not know the information that WPS has on file for you, please contact Medicare. ABILITY Network cannot obtain this information for you.

• You do not need to complete both EDI enrollment forms.

• NEW ELECTRONIC SUBMITTERS:
  - Do not complete this form if you have previously submitted electronic claims to WPS Medicare. If you have previously submitted electronic claims to WPS Medicare, complete the EDI CHANGE OF SUBMITTER FORM.
  - Complete Page 3 of the agreement with your Group/Provider Name and Address as listed on file with WPS Medicare
  - Complete the printed name and title of the person authorized to sign this form. Enter the signature date
  - Do not alter any pre-completed submitter information in the “Type of Submission” section.
  - Enter the group/provider NPI and PTAN assigned to you by Medicare. Note: If you do not know the information that WPS has on file for you, please contact Medicare. ABILITY Network cannot obtain this information for you.
  - Enter the name, phone number, Email address, and fax number of the contact person at the provider’s office.
  - Do not alter any pre-completed submitter information in the bottom box.
  - After printing the forms, obtain the authorized representative signature at the top. Fax the signature page to ABILITY Network enrollment team at 888-837-2232. Do not fax to Medicare.
Submit the completed form to:
ABILITY Network, ATTN: Enrollment
FAX: 888.837.2232 | EMAIL: setup@abilitynetwork.com

INSTRUCTIONS

• PREVIOUS ELECTRONIC SUBMITTERS:
  - Do not complete this form if you have never submitted electronic claims to WPS Medicare.
  - If you have never submitted electronic claims to WPS Medicare, complete the EDI ENROLLMENT FORM
  - Enter the group/provider NPI and PTAN assigned to you by Medicare.
  - Note: If you do not know the information that WPS has on file for you, please contact Medicare. ABILITY Network cannot obtain this information for you
  - Do not alter any pre-completed submitter information.
  - Complete the Group/Provider Name and Address as listed on file with WPS Medicare.
  - Complete the printed name and title of the person authorized to sign this form. Enter the signature date. Enter the name, phone number, Email address, and fax number of the contact person at the provider's office.
  - After printing the forms, obtain the authorized representative signature. Fax the form to ABILITY Network's enrollment team at 888-837-2232. Do not fax to Medicare.

Questions or need assistance?
Contact ABILITY Network Enrollment Department at 888.499.5465 or setup@abilitynetwork.com.
EDI ENROLLMENT FORM

This Agreement notifies Wisconsin Physician Services of the provider’s consent to participate in Electronic Data Interchange (EDI). EDI may include claims and claims attachments, remittances, eligibility/benefits, claim status, and any other electronic information for Centers for Medicare and Medicaid Services (CMS) federal program data (including but not limited to Title XVIII of the Social Security Act (Medicare), and/or Section 1011 of the Medicare Modernization Act) covered under Health Insurance Portability and Accountability Act (HIPAA) Transactions and Code Sets or Section 1011 of the Medicare Modernization Act (MMA) legislation.

A. 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 submit/request electronic transactions on only those beneficiaries with whom the provider has a professional relationship.

5. 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.

6. 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;

7. 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;

8. That it will submit claims that are accurate, complete, and truthful;

9. 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;

10. That it will affix the CMS-assigned unique identifier number (submitter ID) of the provider on each claim electronically transmitted to the A/B MAC, CEDI, or other contractor if designated by CMS;

11. 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;
12. 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;

13. 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;

14. 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 Social Security Act (the Act) (See section 40.1.2.2 below for a complete reference to Medicare’s security requirements);

15. That it will research and correct claim discrepancies;

16. 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.

17. That if it chooses to participate in electronic remittance transactions it will notify the CMS contractor of any changes in third-party services that it has authorized to access this information on their behalf via the EDI Enrollment form;

18. That if it chooses to use a Network Service vendor for eligibility verification transactions it will notify the CMS contractor of any changes in third-party service arrangements via the EDI Enrollment 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 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 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 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.

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 certify that I have been appointed an authorized individual 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 WPS on my behalf.

Provider Name ____________________________________________________________
Provider Address __________________________________________________________
City/State/Zip______________________________________________________________
By ___________________________________________________________ Signature
________________________________________________________________________ Printed name
Title ___________________________________________________________ Date ____________________

Check all lines of business that apply:

Type of Submission (check all that apply)
Electronic Media Claims (EMC)  X  Direct Data Entry (DDE) ________

Group/Provider NPI Number__________________________  Group/Provider PTAN Number________________

WPSSubmiter Number: _____N/A (Required for batch billing only)

Provider Contact Name ___________________________ Phone # __________________________
Provider Email ___________________________ Fax # __________________________

** Please supply the complete name of the Third Party/Clearinghouse/Software vendor **
Name: MEDICAL CLAIM CORP  Address: 88 VALLEY ST
City: BRISTOL State: CT  Zip: 06010  Fax Number: 888-837-2232

Contact: ENROLLMENT  Contact Email address: SETUP@MDOL.COM
(Printed Name)

Contact Phone Number: 888-499-5465 x3506  WPS Submitter Number: 98182
(Please include extension #)

Please mail or fax this completed form for Medicare Part A & B J5 MAC (IA, KS, MO, NE), Medicare Part A & B J8 MAC (IN & MI) or Medicare J5 National Part A to:

WPS Medicare EDI
1717 West Broadway
Madison, WI  53713
Fax: (608) 223-3824
Phone: J5 (866) 518-3285
J8 (866) 234-7331
EDI CHANGE OF SUBMITTER FORM  
(for use by currently enrolled providers only)

Check all lines of business that apply:

<table>
<thead>
<tr>
<th>Group/Provider NPI Number</th>
<th>Group/Provider PTAN Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

Change (aka New) WPS Submitter Number: **98182**  Effective Date: ______________________

**Signature**  
I am authorized to sign this document on behalf of the indicated party. I am aware that any changes to the submitter ID may affect the receipt of electronic remittance advice (ERA). Any changes regarding ERA will require a new ERA Authorization Form.  

Provider Name ___________________________________________

Provider Address ___________________________________________

City/State/Zip __________________________________________

By __________________________________________  Printed name

Signature __________________________________________ Date ______________________

Provider Contact Name ____________________________ Phone # ______________________

Provider Email ____________________________ Fax # ______________________

By filling out the information below, you are authorizing a Third Party/Clearinghouse to send your Electronic Media Claim (EMC)

** Please supply the complete name of the Third Party/Clearinghouse **

<table>
<thead>
<tr>
<th>Name: MEDICAL CLAIM CORP</th>
<th>Address: 88 VALLEY ST</th>
</tr>
</thead>
</table>

City: BRISTOL  State: CT  Zip: 06010  Fax Number: 888-837-2232

Contact: __ ENROLLMENT  Contact Email address: SETUP@MDOL.COM  
(Printed Name)

Contact Phone Number: 888-499-5465 (Please include extension #) 3506

Please mail or fax this completed form to:

Medicare Part A & B J5 MAC (IA, KS, MO, NE)
Medicare Part A & B J8 MAC (IN & MI)
Medicare J5 National Part A
WPS Medicare EDI
1717 West Broadway
Madison, WI. 53713
Fax: (608) 223-3824
Phone: J5 (866) 518-3285
J8 (866) 234-7331

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