



## Railroad Medicare B Claims

### For NEW Enrollment with this payer

If you are a new electronic submitter to Railroad Medicare the following forms must be completed:

- Railroad Medicare EDI Information Form (1 pg)
- Medicare Electronic Data Interchange Enrollment Agreement (3 pgs)

### For RE-Enrollment with this payer

\* If you are currently submitting electronically to RR Medicare go to page 7 in this packet for instructions and agreements.

## Form Completion

### EDI Information Form

- **Provider Name & Provider Number**= Group Name and Group Number. If you have multiple Billing IDs, you may list them separately. If no group number exists, complete with the Individual provider name/number.

### EDI Enrollment Agreement

- Complete for the Group Name/Group Number. If no group number exists complete one agreement for each individual provider.
- **Important!**: 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.
- **Original Signature** Required of the provider or an authorized individual of the group, physician, or the facility. Billing Services may NOT sign on behalf of providers.

## When Completed

Mail with original signature to: **Palmetto GBA  
EDI Operations  
PO Box 10066  
Augusta, GA 30999-0001**

- Registration with the payer may take up to 6 weeks once received.
- To confirm approval you may do one of the following:
  - Call the EDI Dept at (866) 749-4302, options 4, 4, 2. Ask if your billing provider number has been linked to the Payerpath submitter ID RR2564 for electronic claims submission.
  - OR you may complete the online Request for Enrollment Status Form. See next page for link and instructions.
- Contact the Payerpath Help Desk at (877) 623-5706, opt 2 to inform them of your authorization.
- **You will not be able to transmit claims electronically until your authorization is in the Payerpath database.**



## Railroad Medicare B Claims

To check the status of your enrollment:

Click on:

<http://www.palmettogba.com/palmetto/Form+Mailer.nsf/Railroad+Medicare+Enrollment+Status+Form?OpenForm>

Complete the online Railroad Medicare EDI Request for Enrollment Status Form as follows:

|                                    |  |
|------------------------------------|--|
| <b>Company Name:</b>               | <b>Payerpath, A Misys Company</b>                                |
| <b>Contact Name:</b>               | Enter YOUR contact name  |
| <b>Email:</b>                      | Enter YOUR contact email address                                 |
| <b>Railroad Submitter Number:</b>  | <b>RR2564</b>  |
| <b>Phone Number:</b>               | Enter YOUR contact phone number                                  |
| <b>Provider Numbers to Verify:</b> | <b>Enter your group number only for all providers in a group</b> |

Then hit "SEND."

- Railroad Medicare will send an email back to the Email address on the Status Form.
- Contact the Payerpath Help Desk at (877) 623-5706, opt 2 to inform them of your authorization.
- **You will not be able to transmit claims electronically until your authorization is in the Payerpath database.**

|   |  |   |                               |
|---|--|---|-------------------------------|
| <h1 style="margin: 0;">Palmetto GBA</h1> <p style="margin: 0; font-size: small;">PARTNERS IN EXCELLENCE</p>   |  | <h2 style="margin: 0;">Railroad Medicare EDI Information Form</h2>  |                               |
| Mail Completed Form To: Railroad Medicare EDI<br>PO Box 10066<br>Augusta, GA 30999  |  | <input type="checkbox"/> <b>New Request</b> <input type="checkbox"/> <b>Update Info</b><br><b>Current Date:</b> _____ |                               |
| <b>Check One:</b> <input type="checkbox"/> Vendor <input type="checkbox"/> Billing Service <input type="checkbox"/> Submitter <input type="checkbox"/> Clearinghouse  |  |   |                               |
| <b>PART A – PROVIDER DATA</b>   |  |   |                               |
| <b>Name:</b>  |  | <b>Submitter ID (If assigned):</b>  |                               |
| <b>Address:</b>   |  |   |                               |
| <b>City, State, Zip:</b>  |  |   |                               |
| <b>Contact:</b>   |  | <b>E-mail:</b>  |                               |
| <b>Phone:</b> (    )  |  | <b>Ext:</b>   | <b>Fax:</b> (    )            |
| <b>Railroad Medicare Provider Number:</b>   |  |   |                               |
| <b>National Provider Identifier (NPI):</b>  |  |   |                               |
| <b>Check One:</b> <input type="checkbox"/> Provider is Submitter (Provider submits claims directly from their office. Fill out Part B below.)<br><input type="checkbox"/> Provider is with Billing Service/Clearinghouse (Fill out Part C below.) |  |   |                               |
| <b>Request Electronic Remittances (ANSI 835 v4010A1):</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes (must complete Addendum to Electronic Remittance Enrollment Form for Billing Services and Clearinghouses form)              |  |   |                               |
| <b>PART B – EDI SOFTWARE VENDOR DATA</b>  |  |   |                               |
| <b>Check here if you will be using PC-ACE Pro32 Software provided by Palmetto GBA:</b> <input type="checkbox"/>   |  |   |                               |
| <b>Vendor Name:</b>   |  |   |                               |
| <b>Contact:</b>   |  | <b>Phone:</b> (    )  | <b>Ext:</b>                   |
| <b>Address:</b>   |  |   |                               |
| <b>City, State, Zip:</b>  |  |   |                               |
| <b>Vendor ID:</b>   |  | <b>E-mail:</b>  |                               |
| <b>Response Format:</b> <input type="checkbox"/> File <input type="checkbox"/> Report Format  |  | <b>Mode:</b> <input type="checkbox"/> ASYNCH <input type="checkbox"/> CONNECT:Direct <input type="checkbox"/> FTP     |                               |
| <b>Data Compression:</b> <input type="checkbox"/> PKZIP (Version 2.04g or compatible)   |  | <input type="checkbox"/> UNIX   | <input type="checkbox"/> None |
| <b>PART C – EDI BILLING SERVICE/CLEARINGHOUSE DATA</b><br>(TO BE COMPLETED BY BILLING SERVICE/CLEARINGHOUSE)  |  |   |                               |
| <b>Company Name:</b>  |  |   |                               |
| <b>Address:</b>   |  |   |                               |
| <b>City, State, Zip:</b>  |  |   |                               |
| <b>Submitter ID:</b>  |  | <b>E-mail:</b>  |                               |
| <b>Contact:</b>   |  | <b>Phone:</b> (    )  | <b>Ext:</b>                   |
| <b>Response Format:</b> <input type="checkbox"/> File <input type="checkbox"/> Report Format  |  | <b>Mode:</b> <input type="checkbox"/> ASYNCH <input type="checkbox"/> CONNECT:Direct <input type="checkbox"/> FTP     |                               |
| <b>Data Compression:</b> <input type="checkbox"/> PKZIP (Version 2.04g or compatible)   |  | <input type="checkbox"/> UNIX   | <input type="checkbox"/> None |

## 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: \_\_\_\_\_

Railroad Medicare Provider Number: \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

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



## Railroad Medicare B Claims

### For RE-Enrollment with this payer

If you are currently submitting electronically to Railroad Medicare, either of the following forms must be returned to **PGBA**:

- **Railroad Medicare EDI Information Form**
- **Railroad Medicare EDI Provider Change Form**

### Form Completion

\* You only need to complete and submit **ONE** of the following forms to update your clearinghouse information with PGBA.

#### EDI Application

- **Provider Name & Provider Number**= Group Name and Group Number. If you have multiple Billing IDs, you may list them separately. If no group number exists, complete with the Individual provider name/number.

#### Provider Change Form

- All fields required with an asterisk (\*).
- Complete for the Group Name/Group Number. If no group number exists complete one form for each individual provider.
- Previous Billing Agent/Clearinghouse= enter your current Billing Agent or Clearinghouse. The submitter ID and end date are not required.

### When Completed

Mail either form to: **Palmetto GBA  
EDI Operations  
PO Box 10066  
Augusta, GA 30999-0001**

- Registration with the payer may take up to 6 weeks once received.
- To confirm approval you may do one of the following:
  - Call the EDI Dept at (866) 749-4302, options 4, 4, 2. Ask if your billing provider number has been linked to the Payerpath submitter ID RR2564 for electronic claims submission.
  - OR you may complete the online Request for Enrollment Status Form. See next page for link and instructions.
- Contact the Payerpath Help Desk at (877) 623-5706, opt 2 to inform them of your authorization.
- **You will not be able to transmit claims electronically until your authorization is in the Payerpath database.**



## Railroad Medicare B Claims

To check the status of your enrollment:

Click on:

<http://www.palmettogba.com/palmetto/Form+Mailer.nsf/Railroad+Medicare+Enrollment+Status+Form?OpenForm>

Complete the online Railroad Medicare EDI Request for Enrollment Status Form as follows:

|                                    |  |
|------------------------------------|--|
| <b>Company Name:</b>               | <b>Payerpath, A Misys Company</b>                                |
| <b>Contact Name:</b>               | Enter YOUR contact name  |
| <b>Email:</b>                      | Enter YOUR contact email address                                 |
| <b>Railroad Submitter Number:</b>  | <b>RR2564</b>  |
| <b>Phone Number:</b>               | Enter YOUR contact phone number                                  |
| <b>Provider Numbers to Verify:</b> | <b>Enter your group number only for all providers in a group</b> |

Then hit "SEND."

- Railroad Medicare will send an email back to the Email address on the Status Form.
- Contact the Payerpath Help Desk at (877) 623-5706, opt 2 to inform them of your authorization.
- **You will not be able to transmit claims electronically until your authorization is in the Payerpath database.**

|   |      |   |                       |
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| <h1 style="margin: 0;">Palmetto GBA</h1> <p style="margin: 0; font-size: small;">PARTNERS IN EXCELLENCE</p>   |      | <h2 style="margin: 0;">Railroad Medicare EDI Information Form</h2>  |                       |
| Mail Completed Form To: Railroad Medicare EDI<br>PO Box 10066<br>Augusta, GA 30999  |      | <input type="checkbox"/> <b>New Request</b> <input type="checkbox"/> <b>Update Info</b><br><b>Current Date:</b> _____ |                       |
| <b>Check One:</b> <input type="checkbox"/> Vendor <input type="checkbox"/> Billing Service <input type="checkbox"/> Submitter <input type="checkbox"/> Clearinghouse  |      |   |                       |
| PART A – PROVIDER DATA  |      |   |                       |
| Name:   |      | Submitter ID (If assigned):   |                       |
| Address:  |      |   |                       |
| City, State, Zip:   |      |   |                       |
| Contact:  |      | E-mail:   |                       |
| Phone: (    )   | Ext: | Fax: (    )   |                       |
| Railroad Medicare Provider Number:  |      |   |                       |
| National Provider Identifier (NPI):   |      |   |                       |
| <b>Check One:</b> <input type="checkbox"/> Provider is Submitter (Provider submits claims directly from their office. Fill out Part B below.)<br><input type="checkbox"/> Provider is with Billing Service/Clearinghouse (Fill out Part C below.) |      |   |                       |
| <b>Request Electronic Remittances (ANSI 835 v4010A1):</b> <input type="checkbox"/> No<br><input type="checkbox"/> Yes (must complete Addendum to Electronic Remittance Enrollment Form for Billing Services and Clearinghouses form)              |      |   |                       |
| PART B – EDI SOFTWARE VENDOR DATA   |      |   |                       |
| <b>Check here if you will be using PC-ACE Pro32 Software provided by Palmetto GBA:</b> <input type="checkbox"/>   |      |   |                       |
| Vendor Name:  |      |   |                       |
| Contact:  |      | Phone: (    )   | Ext:      Fax: (    ) |
| Address:  |      |   |                       |
| City, State, Zip:   |      |   |                       |
| Vendor ID:  |      | E-mail:   |                       |
| <b>Response Format:</b> <input type="checkbox"/> File <input type="checkbox"/> Report Format  |      | <b>Mode:</b> <input type="checkbox"/> ASYNCH <input type="checkbox"/> CONNECT:Direct <input type="checkbox"/> FTP     |                       |
| <b>Data Compression:</b> <input type="checkbox"/> PKZIP (Version 2.04g or compatible) <input type="checkbox"/> UNIX <input type="checkbox"/> None   |      |   |                       |
| PART C – EDI BILLING SERVICE/CLEARINGHOUSE DATA<br>(TO BE COMPLETED BY BILLING SERVICE/CLEARINGHOUSE)   |      |   |                       |
| Company Name:   |      |   |                       |
| Address:  |      |   |                       |
| City, State, Zip:   |      |   |                       |
| Submitter ID:   |      | E-mail:   |                       |
| Contact:  |      | Phone: (    )   | Ext:      Fax: (    ) |
| <b>Response Format:</b> <input type="checkbox"/> File <input type="checkbox"/> Report Format  |      | <b>Mode:</b> <input type="checkbox"/> ASYNCH <input type="checkbox"/> CONNECT:Direct <input type="checkbox"/> FTP     |                       |
| <b>Data Compression:</b> <input type="checkbox"/> PKZIP (Version 2.04g or compatible) <input type="checkbox"/> UNIX <input type="checkbox"/> None   |      |   |                       |



**MEDICARE**  
**RAILROAD CARRIER**

Technology Support Center  
1-866-749-4301

**RAILROAD MEDICARE EDI PROVIDER CHANGE FORM**

This form is to be completed by a Provider when the following changes occur:

- Discontinue use of a billing agent or clearinghouse
- Use of a new billing agent or clearinghouse

\* Provider Name: \_\_\_\_\_

\* Contact Name: \_\_\_\_\_

\* Mailing Address: \_\_\_\_\_

\* City: \_\_\_\_\_ \* State: \_\_\_\_\_ \* ZIP: \_\_\_\_\_

\* Phone #: \_\_\_\_\_ FAX #: \_\_\_\_\_

\* E-mail Address: \_\_\_\_\_

\* Provider Number: \_\_\_\_\_

NPI: \_\_\_\_\_

Transaction(s)  
Affected:

ANSI 837 Claim

ANSI 835 Remittance

ANSI 270/271 Eligibility

ANSI 276/277 Claim Status

Previous Billing Service/Clearinghouse Agent Name: \_\_\_\_\_

Submitter ID of Billing Service/Clearinghouse (if available): \_\_\_\_\_

End Date (if applicable): \_\_\_\_\_

\* New Billing Service / Clearinghouse Agent Name: \_\_\_\_\_

Submitter ID of Billing Service/Clearinghouse (if available): \_\_\_\_\_

Begin Date (if applicable): \_\_\_\_\_

Please mail the completed form to: Palmetto GBA Railroad Medicare EDI Operations  
PO Box 10066  
Augusta GA 30999-0001

If you have any questions, please contact the Palmetto GBA Technology Support Center at 1-866-749-4301.

**Palmetto GBA**

Medicare Electronic Data Interchange  
Post Office Box 10066 • Augusta, Georgia • 30999-0001