

## Provider Authorization Form Instructions

The purpose of the notice is to authorize a clearinghouse and/or billing service as an electronic submitter and recipient of electronic claims data. It is important that instructions are followed and that all required information is completed. Incomplete forms will be returned to the applicant, thus delaying processing. Please retain a copy of this complete notice for your records.

**Please retain a copy of this completed form for your records.**


You must submit a completed EDI Application Form when submitting this form. The Provider Authorization form must be completed and signed by the Provider.

The field descriptions listed below will aid in completing the notice properly.

Form Field Name	Instructions for Field Completion
<b>Line of Business Information</b>	Indicate the line of business and state for which you will be transmitting. Select all that apply to this request.
<b>Action Requested</b>	Indicate the type of service(s) you are authorizing the Submitter to access. Check all that apply.
<b>Provider Name</b>	List the provider name for which this Provider Authorization Form is being completed. This name must match the name submitted on the CMS 855 Medicare Enrollment Application.
<b>Provider E-mail Address</b>	The e-mail address of the provider to receive EDI notifications.
<b>Provider Number</b>	List the provider PTAN whose Medicare claims, electronic remittances, response reports or DDE will be accessed by the submitter listed on the EDI Application. A separate Provider Authorization Form is required for each PTAN.
<b>NPI</b>	Indicate the National Provider Identifier (NPI).
<b>Name/Title</b>	The name and title of the person Palmetto GBA will contact if there are questions regarding this Authorization Form.
<b>Address</b>	The mailing and/or the physical address of the provider. (Only one valid address has to be submitted.)
<b>City, State, Zip</b>	The city, state and zip code of the provider.
<b>Phone Number</b>	The area code and phone number of the Contact Person listed.
<b>Submitter's Name</b>	The name of the Submitter you are authorizing for the above services.
<b>Signature</b>	The signature of the listed provider's authorized contact.
<b>Date</b>	The date the form was signed.

### Provider Authorization Form

This information is intended as reference to be used in addition to information from the Centers for Medicare & Medicaid Services (CMS) and American National Standard Institute (ANSI). Use or disclosure of the data contained on this page is subject to restriction by Palmetto GBA.

	<h2 style="margin: 0;">Provider Authorization Form</h2>
<b>This form must be completed and signed by the Provider ONLY.</b>	
<b>Line of Business Information:</b> <input type="checkbox"/> SC Part A <input type="checkbox"/> NC Part A <input type="checkbox"/> HHH	
<b>Action Requested:</b> <input type="checkbox"/> Electronic Claims Submissions <input type="checkbox"/> Electronic Remittance <input type="checkbox"/> Electronic Response Reports <input type="checkbox"/> Online Inquiry Services (DDE)	
<b>Provider for whom Submitter will be granted access</b>	
<b>Provider Name:</b> _____	
<b>Provider E-mail Address:</b> _____	
<b>Provider Number:</b> _____ <b>NPI:</b> _____	
<b>Name:</b> _____	
<b>Title:</b> _____	
<b>Address:</b> _____ _____	
<b>City:</b> _____ <b>State:</b> _____ <b>ZIP:</b> _____	
<b>Phone:</b> _____	
<b>Submitter Name:</b> _____	
I hereby authorize the above submitter to receive the items notated above on my behalf. I understand that these items contain payment information concerning my processed Medicare claims. I am authorized to endorse this access on behalf of my company, and I acknowledge that is my responsibility to notify Palmetto EDI in writing if I wish to revoke this authorization.	
<b>Signature:</b> _____	<b>Date:</b> _____

Please complete and return this form, with the EDI Application Form, to:

Palmetto GBA  
 EDI Operations, AG-420  
 PO Box 100145  
 Columbia SC 29202-3145

## EDI Application Form Instructions

The purpose of the **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 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.

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>Line of Business Information</b>	Indicate the line of business and state for which you will be transmitting. Select all that apply to this request.
<b>Action Requested:</b> Add Provider(s) Change/Update Submitter Information Delete Apply for New Submitter ID Apply for New Receiver 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 Provider(s)</b>.</li> <li>If you request to change or update information about the Submitter, check <b>Change/Update Submitter Information</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> <li>If you are a new applicant, check <b>Apply for New Receiver ID (NC A only)</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 if requested. 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>Receiver ID</b>	The receiver ID is used by the remittance receiver to download remittance advices/notices via Palmetto GBA electronically. For new applicants, this field should be left blank, as Palmetto GBA will assign this ID if requested. For changes or additions, enter the Receiver ID to which the change/additions should be applied. <b>Valid for NC Part A only.</b>
<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>Owner Name(s)</b>	Enter the name of the individual(s) who owns the entity listed above.
<b>Type of Submitter</b>	Check the appropriate box.
<b>EDI 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 for this location.
<b>Address</b>	The mailing address of the submitter.
<b>City, State, Zip</b>	The city, state and zip code of the submitter.
<b>Submitter E-mail Address</b>	The e-mail address of the contact person listed. <b>Note: This will be the primary method of communication. This e-mail address will also receive EDI Tracking Numbers used to monitor the processing status of your EDI forms.</b>


Form Field Name	Instructions for Field Completion
<b>Claim Submission Mode of Communication</b>	There are four available modes of communication modes that can be used for claim submission. Check <b>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> <li>• <b>Leased FTP</b>: File transfer protocol transmission via the Internet or Network-based connection.</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> <li>• <b>Leased FTP</b>: File transfer protocol transmission via the Internet or Network-based connection.</li> </ul>
<b>Report Response Format</b>	Check the format in which you will receive GPNet Claims 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>Vendor ID</b>	Include Vendor ID number if known.
<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.) This name must match the name submitted on the CMS 855 Medicare Enrollment Application.
<b>Provider E-mail address</b>	Indicate the e-mail address for the provider listed above. This e-mail address will be the primary source of communications regarding approval of changes to their EDI options.
<b>Provider Number</b>	Indicate the Medicare Provider Number for each provider listed.
<b>NPI</b>	Include the National Provider Identifier (NPI).
<b>Enrollment Form Attached:</b> Y/N	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 enrollment form.</b>
<b>Provider Authorization Form Attached:</b> Y/N	Indicate “Y” for Yes or “N” for No. A provider authorization form is required to authorize a clearinghouse and/or billing service as an electronic submitter and recipient of electronic claims data.
<b>Submit Claims</b>	Check this box if the application is for the submitter to submit claims electronically for this provider.
<b>Receive Reports</b>	Check this box if the submitter wants to receive response reports electronically for the provider indicated.
<b>Receive Electronic Remittances</b>	Check this box if the submitter wants to receive Electronic Remittances for the provider indicated. Provider must be submitting claims electronically to receive Electronic Remittances.
<b>Online Inquiry</b>	Check this box if the submitter currently uses or plans to use the Online Inquiry Services (DDE). Note: The Online Inquiry Form must be submitted if this option is selected.

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 processed within 20 business days of receipt of completed forms. Submit completed form to:

Palmetto GBA  
EDI Operations, AG-420  
PO Box 100145  
Columbia SC 29202-3145

#### EDI Application Form

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		<h2 style="margin: 0;">EDI Application</h2>	
<b>Line of Business Information:</b> <input type="checkbox"/> SC Part A <input type="checkbox"/> NC Part A <input type="checkbox"/> HHH			
<b>Action Requested:</b> <input type="checkbox"/> Add Provider(s)		<input type="checkbox"/> Change / Update Submitter Information	
<input type="checkbox"/> Delete <input type="checkbox"/> Apply for New Submitter ID		<input type="checkbox"/> Apply for New Receiver ID (NC A Only)	
Submitter ID (if available): _____		Date: _____	
Receiver ID: _____			
Submitter Name: _____			
Owner Name: _____			
<b>Type of Submitter:</b> <input type="checkbox"/> Software Vendor <input type="checkbox"/> Billing Service <input type="checkbox"/> Provider <input type="checkbox"/> Clearinghouse			
EDI Contact Person: _____			
Phone: _____		Fax: _____	
Address: _____ _____			
City: _____		State: _____	ZIP: _____
Submitter E-mail Address: _____			
Note: E-mail will be the primary method of communication.			
<b>Claim Submission Mode of Communication:</b>		<input type="checkbox"/> GPNet Asynchronous	<input type="checkbox"/> Dial-up FTP
		<input type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Leased FTP
<b>Report / Electronic Remittance Retrieval Mode of Communication:</b>		<input type="checkbox"/> GPNet Asynchronous	<input type="checkbox"/> Dial-up FTP
		<input type="checkbox"/> CONNECT: Direct (NDM)	<input type="checkbox"/> Leased FTP
<b>Report Response Format:</b>		<input type="checkbox"/> File	<input type="checkbox"/> Report
<b>Data Compression:</b>		<input type="checkbox"/> Uncompressed (GPNet Default)	<input type="checkbox"/> UNIX-Compress
		<input type="checkbox"/> PKZIP	
Name of Software Vendor: _____		Vendor Security ID: _____	

**Providers for Whom Submitter Will Be Transmitting**

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims <input type="checkbox"/> Receive Reports <input type="checkbox"/> Receive Electronic Remittances <input type="checkbox"/> Online Inquiry Services	

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## EDI Application

### Multiple Providers List

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

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

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

Provider Name: _____	
Provider E-mail Address: _____	
Provider Number: _____	NPI: _____
Enrollment Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No	Provider Authorization Form Attached? <input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Submit Claims	<input type="checkbox"/> Receive Reports
<input type="checkbox"/> Receive Electronic Remittances	<input type="checkbox"/> Online Inquiry Services

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