Como llenar los protocolos de CEDI

Para poder registrarse en CEDI (equipo médico) se necesita llenar 3 protocolos en su portal.

**CEDI Enrollment Agreement Form**

http://apps.ngsmedicare.com/applications/cedisupplierauthform.aspx

Este debe ser llenado de la siguiente forma:

Este formulario está disponible en la siguiente dirección:
http://apps.ngsmedicare.com/applications/CEDIEnrollmentAgreement.aspx

National Government Services

Help

**CEDI Enrollment Agreement Form** * - Required

Medicare Supplier Name: Nombre del proveedor *
Contact Name: Persona contacto *
Address: Dirección *
City/State/Zip: Ciudad PR * Zip *
Email: Correo electrónico *
Verify Email: Correo electrónico *
Phone: Teléfono * Ext

Submitter Status: Existing Submitter
Submitter ID: C08404841 *
Submitter Name: Inmediata *
Submitter Type: Clearing House *
PTAN(s): PTAN * NPI(s): NPI *

A. The provider agrees to the following provisions for submitting Medicare claims electronically to CMS or to CMS' FIs, Carriers, RHHIs, A/B MACs or CEDI:

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 FIs, Carriers, RHHIs, 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

Hacer un click. → ☐ I have read and accept the terms of the above agreement.

Authorized Signature Name: Nombre del proveedor o persona autorizada

IMPORTANT: Once you click on the "Submit" button, this form must be printed, signed, dated, and then faxed to CEDI using the fax number located on the form. Forms that are not printed, signed, dated, and faxed to CEDI will not be processed. Per CMS regulations, it is required to submit both pages 1 and 2 of the EDI Enrollment Agreement. Failure to submit both pages may delay processing.

ALL pages of ALL forms must be SIGNED, DATED, and FAXED to 315-442-4299 within 10 business days or the request will be rejected. Please be sure to fax multiple forms for the same request TOGETHER and include a cover letter. Faxes not received within 10 days of submitting the form(s) on line will be rejected and new forms will be required to be submitted.

Submit ← Hacer un click. Luego imprimir, firmar, colocarle la fecha y enviar al número de fax (315-442-4299).

**CEDI Supplier Authorization Form**

http://apps.ngsmedicare.com/applications/CEDIEnrollmentAgreement.aspx

Help

# CEDI SUPPLIER AUTHORIZATION FORM

## U.S. Department of Health and Human Services

**Select Transactions Authorized for this Submitter**

- [x] Health Care Claim (837 v5010A1)
- [x] Health Care Claim Status Request & Response (276/277 v5010)
- [x] Health Care Claim Payment/Advice (835 v5010A1)
- [ ] NCPDP Claims D.0

**Solo marcar los primeros 3 de arriba hacia abajo.**

**Submitter and/or Receiver Information**

| Field | Value |
|---|---|
| Entity Name | Inmediata * |
| Operating as a | Clearinghouse * |
| Submitter ID | C08404841 * |
| Street | 636 Ave. San Patricio * |
| City/State/Zip | San Juan * / PR * / 00920 * |
| Contact Name | Sylvia Gonzalez * |
| Phone Number | 787-774-0606 * Ext 404 |
| E-mail | sgonzalez@inmediata.com * |
| Verify E-mail | sgonzalez@inmediata.com * |

**DME Supplier Information**

| Field | Value |
|---|---|
| Supplier Name | Nombre del Proveedor o Suplidor * |
| Street | Direccion * |
| City/State/Zip | Ciudad * / PR * / Zipcode * |
| Contact Name | Nombre Contacto * / Apellido Contacto * |
| Phone Number | Telefono * Ext Ext. |
| E-mail | Direccion correo electronico * |
| Verify E-mail | Direccion correo electronico * |

**List your NPI and your NSC/PTAN Number(s) Below (Required):**

| PTAN(s) | NPI |
|---|---|
| # de PTAN * | # de NPI * |
| | |
| | |
| | |
| | |

***IMPORTANT: Once you click on the "Submit" button, this form must be printed, signed, dated, and then faxed to CEDI using the fax number located on the form. Forms that are not printed, signed, dated, and faxed to CEDI will not be processed. Requests received 30 days past the Signature date will be returned.***

ALL pages of ALL forms must be SIGNED, DATED, and FAXED to 315-442-4299 within 10 business days or the request will be rejected. Please be sure to fax multiple forms for the same request TOGETHER and include a cover letter. Faxes not received within 10 days of submitting the form(s) on line will be rejected and new forms will be required to be submitted.

***Enter the name and title of the person authorized to sign on behalf of the supplier below.***

| Field | Value |
|---|---|
| DME Supplier Signature | Firma de Persona Autorizada * |
| DME Supplier Title | Titulo de Suplidor * |

Submit

**Oprima este boton para finalizar.**

CMS' information security policy strictly prohibits the sharing or loaning of Medicare assigned IDs and passwords. Users should take appropriate measures to prevent unauthorized disclosure or modification of assigned IDs and passwords. Violation of this policy will result in revocation of all methods of system access, including but not limited to EDI front-end access or EDC RACF user access.

**CEDI ERA Enrollment Form**

http://www.ngscedi.com/eraform/cedieraenrollmentform.aspx

# CEDI ERA Enrollment Form

Please Complete and return:
Fax: (315) 442-4299

Common Electronic Data Interchange (CEDI) enrollment forms are completed and submitted online. After completing this form below, you must select the **Submit** button, print, sign, and fax the form to the number located on the printed form. **Do not print the screen before you select the Submit button.**

* **Required Field**

## PROVIDER INFORMATION

**Provider Name** NOMBRE DE PROVEEDOR *

**Doing Business As Name (DBA)** NOMBRE DE NEGOCIO

**Provider Address**

**Street Address** DIRECCION *

**City** CIUDAD *

**State/Province** PR ▼ * **Zip Code/Postal Code** ZIP CODE *

**Country Code** US ▼

## PROVIDER IDENTIFIERS INFORMATION

**Provider Identifiers** Provider Federal Tax Identification Number ▼ *

**Provider Federal Tax Identification Number (TIN)** TAX ID *

**National Provider Identifier (NPI)** # NPI *

Elija entre Seguro Social Personal o Seguro Social Patronal (Tax ID)

**Other Identifier(s)**

Elija el tipo de proveedor o especialidad.

**Assigning Authority** MEDICARE

**Trading Partner ID** C08404841

**Provider Type** Medical Supply Company ▼

**Provider Transaction Access Number (PTAN)** # PTAN *

## PROVIDER AGENT INFORMATION

| Field | Value | |
|---|---|---|
| Provider Agent Name | INMEDIATA | * |

**Agent Address**

| Field | Value | |
|---|---|---|
| Street Address | 636 AVE. SAN PATRICIO | * |
| City | SAN JUAN | * |
| State/Province | PR | * |
| Zip Code/Postal Code | 00920 | * |
| Country Code | US | * |
| Provider Agent Contact Name | SYLVIA GONZALEZ | * |
| Title | CUSTOMER SERVICE | * |
| Telephone Number | 787-774-0606 | * |
| Telephone Number Extension | 404 | |
| E-mail Address | sgonzalez@inmediata.com | * |
| Fax Number | 787-774-6976 | * |

## ELECTRONIC REMITTANCE ADVICE INFORMATION

| Field | Value | |
|---|---|---|
| Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier) | National Provider Identifier (NPI) | * |
| Method of Retrieval | Clearinghouse | * |

## ELECTRONIC REMITTANCE ADVICE CLEARINGHOUSE INFORMATION

| Field | Value | |
|---|---|---|
| Clearinghouse Name | INMEDIATA | * |
| Clearinghouse Contact Name | SYLVIA GONZALEZ | * |
| Telephone Number | 787-774-0606 | * |
| E-mail Address | sgonzalez@inmediata.com | * |

## ELECTRONIC REMITTANCE ADVICE VENDOR INFORMATION

| Field | Value | |
|---|---|---|
| Vendor Name | Inmediata Health Group | * |
| Vendor Contact Name | Vendor Information Already Provided | * |
| Telephone Number | 787-783-3233 | * |
| E-mail Address | edipayer@inmediata.com | * |

## SUBMISSION INFORMATION

**Reason for Submission** New Enrollment ▼ *

Elija entre Nueva Registracion o Cambio.

## AUTHORIZED SIGNATURE

| | |
|---|---|
| **Written Signature of Person Submitting Enrollment** | |
| **Printed Name of Person Submitting Enrollment** | NOMBRE DE PERSONA AUTORIZADA * |
| **Printed Title of Person Submitting Enrollment** | TITULO * |

*"Providers who have a signed ERA Enrollment Form on file with a particular FI, Carrier, RHHI, A/B MAC, or CEDI are not required to submit a new signed ERA Enrollment Form to the same FI, Carrier, RHHI, A/B MAC, or CEDI each time they change their method of electronic billing or begin to use another type of EDI transaction, e.g., changing from direct submission to submission through a clearinghouse or changing from one billing agent to another. Additionally, providers are not required to notify their FI, Carrier, RHHI, A/B MAC, or CEDI if their existing clearinghouse begins to use alternate software; the clearinghouse is responsible for notification in that instance.*

*FIs, Carriers, RHHIs, A/B MACs, and CEDI must inform providers that providers are obligated to notify their FI, Carrier, RHHI, A/B MAC, or CEDI in writing in advance of a change that involves a change in the billing agent(s) or clearinghouse(s) used by the provider, the effective date on which the provider will discontinue using a specific billing agent and/or clearinghouse, if the provider wants to begin to use additional types of EDI transactions, or of other changes that might impact their use of ERA.*

*When an FI, Carrier, RHHI, A/B MAC, or CEDI receives a signed request from a provider or supplier to accept ERA transactions from or send ERA transactions to a third party, the FI, Carrier, RHHI, A/B MAC, or CEDI must verify that an ERA Enrollment Form is already on file for that provider or supplier. The request cannot be processed until both are submitted/issued.*

*The binding information in an ERA Enrollment Form does not expire if the person who signed that form for a provider is no longer employed by the provider, or that FI, Carrier, RHHI, A/B MAC, or CEDI is no longer associated with the Medicare program. Medicare responsibility for ERA oversight and administration is simply transferred in that case to that entity that CMS chooses to replace that FI, Carrier, RHHI, A/B MAC, or CEDI, and the provider as an entity retains responsibility for those requirements mentioned in the form regardless of any change in personnel on staff.*

*The note at the end of the enrollment agreement language indicates that either party can terminate that agreement by providing 30 days advance notice. There is an exception to that requirement. In the event an FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI detects abuse of use of an ERA system, or discovers potential fraud or abuse, that FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI is to immediately terminate system access for receipt of ERA transactions by that individual or entity. A decision by a FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI to terminate or suspend EER access in such a situation is not subject to appeal by the individual or entity that loses ERA access.*

***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 FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI, 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."*

☑ I have read and agree with the above terms. *

Debe estar marcado

*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 National Government Services, Inc. on my behalf.*

**Provider's Name** NOMBRE DE PROVEEDOR *

**Title** TITULO *

**Street Address** DIRECCION *

**City** DIRECCION *

**State/Province** PR * **Zip Code/Postal Code** ZIP CODE *

**Firma**

**Signature**

**Printed Name** NOMBRE DE PROVEEDOR *

By signing this Agreement, the provider/trading partner attests that it has executed Business Associate Agreements (contracts), as mandated by HIPAA and ARRA/HITECH with each of its business associates. Moreover, the trading partner attests that it has full responsibility, as mandated by HIPAA and ARRA/HITECH, for notification of breaches of protected health information caused by the trading partner or its business associates.

Submit

**Oprima aqui para finalizar.**

Post Date 12/30/13


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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Nota importante:

Una vez completado los documentos, debe darle al botón de Submit, imprimir cada documento, firmarlos y enviarlos por Fax: (315) 442-4299.