MD Resource Solutions, Inc
501 Cedar Road
Suite 2C
Chesapeake, VA 23322
billing@mdrsinc.com
(888) 647-6377

WWW.MDRSINC.COM

Thank you for your interest in our professional billing services.

MD Resource Solutions Inc. is a professional billing service company. Our goal is to provide efficient billing services to your practice.

New client checklist:

- ☐ New Client Engagement Letter
- ☐ Practice Profile Form
- ☐ Medicare EDI Form
- ☐ Railroad Medicare EDI Form
- ☐ Railroad Medicare EDI Clearinghouse Change Form
- ☐ TRICARE EDI Form
- ☐ TRICARE for Life EDI Form

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MD Resource Solutions All Inclusive Services

- Electronic or paper submission of client's medical insurance claims to insurance companies and government payors within 24 hours reciept of complete information from client.
- Where electronic submission is not yet available, paper claims will be sent.
- Follow-up of insurance claims and aggressively pursue late or denied claims.
- Statements mailed to patients for any balances due after insurance payment.
- MDRS will proceed with collection procedures for outstanding patient balances over 30 days.
- Daily pick-up of all superbills, EOB's etc. from office or practice can request a secure scanner to be placed in their office.
- MDRS will supply practice with A/R and productivity reports monthly or as requested.

MD Resource Solutions Does Not Provide

- MDRS does not guarantee that Client will receive payment from patients and/or insurance company(ies).
- MDRS will not provide collection services for any patient or insurance balances incurred prior to commencement of our service.

INFORMATION TO BE PROVIDED BY CLIENT

- Client will provide MDRS with all necessary practice information, such as provider numbers, insurance numbers, codes and charges for the services provided by Client, etc. Additional forms have been supplied to obtain this information.

- Client will provide all patient demographics and copies (front and back) of insurance cards and superbills to MDRS within a reasonable amount of time after pt visit.

- Client will verify patient insurance information, eligibility and verification and co-pays/deductibles before providing medical services.

- Client will provide copies of all EOB's and ERA's and payments received by/from other sources, such as co-pays, self-pays and payment on patient accounts, within a reasonable time of receipt.

- Client will provide any other information helpful for MDRS to process, submit and follow up on claims and accounts receivable within 2 business days.

- Client to notify MDRS of any patient calls regarding statements, payments due, etc. MDRS will contact the patient.

FEES for MDRS Services

- There is no cost to client for set-up into MDRS's system.

- Fees for all billing services are 5% of all revenues to practice including payments from insurance, patient payments, patient co-pays, patient deductibles, patient co-insurance, self-pays, medical records request fees, and medical records request fees from any patient personal injury suit lawyers.

- Practice will receive an invoice from MDRS on the 10th of each month, for collections from the prior month. Invoice to be paid within 5 business days.

HIPAA Compliance

Each patient's information will remain confidential through the Health Insurance Portability and Accountability Act (HIPAA) and all Privacy Regulations. No information shall be disclosed to anyone except where necessary for MDRS to perform its normal duties of medical billing. MDRS and its Business Partners, (such as our software vendor and clearing house), are fully HIPAA compliant.

Cancellation of Agreement: This Agreement is automatically renewable for one (1) year unless Client gives prior written notice to MDRS within the (30) days prior to the one (1) year expiration of the Agreement. It shall be mutually agreed to by the parties that all other terms and condition in this Agreement will remain the same. Any increase in compensation to MDRS or any change in terms of this Agreement shall be completed by written notice within thirty (30) days prior to the one (1) year expiration of the Agreement. This Agreement shall terminate if MDRS is unable to operate for any reason, including but not limited to, building destruction or any other reason which precludes MDRS to operate the business on an ongoing basis.

Termination on Occurrence of Stated Events: This Agreement will automatically terminate upon the occurrence of any of the following events: Bankruptcy or insolvency of either party from any cause whatsoever; Sale of the business of either party; Death or dissolution of either party from any cause whatsoever; Assignment of this Agreement by either party without the consent of the other party.

Modification: Neither party may modify this Agreement without the written consent of the other party, except as otherwise required by Virginia law with regard to medical billing.

Assignment: This agreement may be assignable with the prior written consent of the parties, and such consent will not be unreasonably withheld.

Governing Law: This Agreement is entered into under and is governed by Virginia Law.

Attorney Fees: If client is at fault for any breach of this contract, then client shall pay MDRS's reasonable attorney fees and court costs.

Headings: The headings in this Agreement are for convenience only, and will not be used to modify, limit, or extend any provision.

Separability: This Agreement is separable. If Virginia law or a Court order declares any provision of this Agreement void, invalid, or unenforceable, all other provisions of this Agreement remain binding.

Complete Agreement: In addition, this Agreement supersedes any and all agreement, both oral and written, between the parties with respect to the rendering of services by MDRS for client, and contains all of the covenants and agreements between the parties with respect to the rendering of these services in any manner whatsoever. This Agreement is the complete understanding of the parties. Each party acknowledges that no representations, inducements, promises, or agreements, written or oral, have been made by either party, or by anyone acting on behalf of either party, that are not embodied in this Agreement.

MDRS is hereby authorized by Client to contact the patients, insurance companies, and all other parties deemed necessary, and to obtain any information needed to perform medical billing services.

This Agreement is made on _____, 2010, between _____, with offices at _____ ("Client") and MD Resource Solutions, Inc., a corporation with an office located at 501 Cedar Road, Suite 2C Chesapeake, VA 23322, ("MDRS")

Term of Contract: This Agreement will become effective on _____, 2010, and will continue to be in effect for one year or unless terminated as provided herein.

_____	_____
Client Signature	MD Resource Solutions, Inc. Signature
_____	_____
Title	Title
_____	_____
Date	Date

MD Resource Solutions, Inc
501 Cedar Road Suite 2C
Chesapeake, VA 23322
(888) 647-6377
billing@mdrsinc.com
www.mdrsinc.com

Practice Profile

Practice Name _____

Address _____

Address (continued) _____

Practice Contact Name _____

Practice Contact Number _____

Practice Fax Number _____

Tax ID _____

CLIA Certification Number _____

Workers Comp accepted? _____

Personal Injury Suit cases? _____

Does office allow professional discounts? _____

If Yes, please note what they are _____

Participating Payors and Provider Numbers

Physician	Physician(s) NPI Number	Payor	Provider Number

Physician	Physician(s) NPI Number	Payor	Provider Number

Frequent CPT Codes Used by Practice and Charge	
Code	Charge

Frequent CPT Codes Used by Practice and Charge (continued)	
Code	Charge

ICD-9 codes used by practice	

Referring Providers	

Referring Providers (continued)	

Payor Mix (Estimate)	
Insurance	% of Practice

MEDICARE VIRGINIA (TRAILBLAZERS)
PRE-ENROLLMENT INSTRUCTIONS – 00904

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is 5 business days after receipt.

WHAT FORM(S) SHOULD I COMPLETE?

IF you have **NEVER** submitted electronically to Trailblazers, complete the following two forms:

- ✓ EDI Provider Information Form
- ✓ Enrollment Agreement

IF you have submitted electronically to Trailblazers, and are switching to Office Ally, you only need to complete the following form:

- ✓ Electronic Data Interchange (EDI) Provider Change Form

WHO CAN SIGN THE FORM(S)?

- The Provider must sign the form.

WHERE SHOULD I SEND THE FORM(S)?

- The form(s) must be mailed to:
  TrailBlazer Health Enterprises, LLC
  EDI Operations, AG-507
  P.O. Box 100249
  Columbia, SC 29202-3249

HOW DO I CHECK STATUS?

- Call 866-749-4302 and have your Medicare Provider Number and/or NPI Number ready.
- Ask if your Provider Number and/or NPI Number have been linked to Office Ally's submitter# RR3426.
- Once you have received notification that you have been linked you MUST contact Office Ally at 866-575-4120, option 1 to notify us of the approval BEFORE submitting claims for electronic transmission.

WHAT PROVIDER NUMBERS DO I USE?

- NPI Number
- Medicare Provider Number

Thank you for your interest in Electronic Media Claims (EMC). Enclosed is a summary of the available electronic claims services for Medicare Part A/B providers. Also enclosed are the necessary applications, enrollment forms and instructions for their completion.

Section 1 - General Electronic Data Interchange (EDI) Enrollment Documents – Contains the **required** enrollment documents that must be completed, signed and returned to our office prior to initiation of electronic claims submission or inquiry.

Section 2 - Direct Data Entry (DDE) for Part A – Contains connectivity information regarding claim entry via on-line DDE.

Section 3 - Free Billing Software

Section 4 - Testing Requirements

We are committed to making your transition to EMC as smooth as possible. If you have any questions regarding the information contained in this package, please feel free to contact the TrailBlazer Health Enterprises® EDI Technology Support Center toll free at (866) 749-4302.

Be Compliant: Take Control of Your Accounts Receivable
Sign up today to receive your remittances electronically. Download and print your remittances more quickly. CMS is focused on increasing the number of providers who receive their remittances electronically and on decreasing the printing and mailing costs associated with hard copy remittances. Complete your forms today!

Important Note on Staying Up-To-Date Online
Register on the TrailBlazer℠ Web site at www.trailblazerhealth.com to receive EDI news electronically. By selecting "Listserv" (which displays at the top of all pages) and completing a user profile, you will be notified via e-mail when new or important EDI information is added to the Web site. If you have already registered, please ensure your profile has been updated for all new applicable EDI categories.

SECTION 1 – GENERAL EDI ENROLLMENT DOCUMENTS

EDI Provider Information Form

The EDI Provider Information Form is used for initial EDI set up. The information on this form is also used to verify requester information submitted on additional EDI applications. Please follow the instructions carefully when completing the form. Incomplete forms will be returned to the applicant, thus delaying processing.

The name of the provider (an authorized officer's name) must be printed in the space provided and that authorized officer's title and signature must also be included. The name and signature **must match** what is submitted on the EDI Agreement Form.

Providers who submit claims directly from their office will be assigned a Submitter ID. Providers are not permitted to share their personal EDI access number (submitter ID) or password with:

- Any billing agent, clearinghouse/network service vendor.
- To anyone on their staffs who has no need to see the data for completion of a valid electronic claim, to process a remittance advice for a claim, to verify beneficiary eligibility or to determine the status of a claim.
- Any non-staff individual or entity.

The EDI submitter ID and password act as an electronic signature; therefore, the provider would be liable if any entity performed an illegal action while using that EDI submitter ID and password. Likewise, a provider's EDI submitter ID and password are non-transferable, meaning they may not be given to a new owner of the provider's operation. New owners must obtain their own EDI submitter ID and password.

Medicare Electronic Data Interchange Enrollment Agreement

The EDI Enrollment Agreement should be submitted when enrolling for electronic billing. It should be reviewed and signed **only** by the provider to ensure each is knowledgeable of the enrollment request and the associated requirements:

- If the submitter will be submitting for multiple providers, each provider whose claim data will be submitted must complete this form.
- The entire form must be read carefully and then dated with the day, month and year.
- The name of the provider (an authorized officer's name) must be printed in the space provided and that authorized officer's title and signature must also be included. The name and signature **must match** what is submitted on the EDI Provider Information Form.
- When completed, **all three pages** of the properly executed **EDI Enrollment Agreement** must be returned **with** the EDI Application form.

EDI Vendor / Billing Service / Clearinghouse ID Request Form

The purpose of this form is to establish a Vendor / Billing Service / Clearinghouse ID for software vendors, clearinghouses and billing services to submit claim files, or retrieve response reports. Please follow the instructions carefully when completing the form. Incomplete forms will be returned to the applicant, thus delaying processing. The information submitted on this form will be included in the Certified Vendor Directory once you have successfully passed the testing requirements (see Section 3 – Testing Requirements).

Submitters are responsible for notifying Medicare if any information on this form changes, including change of software being used to submit files to TrailBlazer.

Additional Information for Providers

Providers who have contracted with a third party (clearinghouse/network service vendor or a billing agent) are required to have that third party sign an agreement in which they agree to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. These agreements are not to be submitted to Medicare, but are to be retained by the providers.

Providers are obligated to notify Medicare by hard copy of:

- Any changes in their billing agents or clearinghouses.
- The effective date they will discontinue using a specific billing agent or clearinghouse.
- If they want to begin using additional types of EDI transactions.
- Other changes that might impact their use of EDI.

Providers are not required to notify Medicare if their existing clearinghouses begin to use alternate software. The clearinghouses are responsible for notification in this instance.

Note: The binding information in an EDI Enrollment Form does not expire if the person who signed the form for a provider is no longer employed by the provider.

The EDI Application Process for Providers

Step 1: Complete the EDI application.

Step 2: Complete and sign the Medicare Electronic Data Interchange Enrollment Agreement. The Medicare provider must complete and sign this form.

Step 3: Complete documents and mail to the following address:

MAILING ADDRESS	DELIVERY ADDRESS
TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 P.O. Box 100249 Columbia, SC 29202-3249	TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 Building One 2300 Springdale Drive Camden, SC 29020-1728

Step 4: Retain the completed forms for your records.

The EDI Application Process for Vendors, Billing Services and Clearinghouses

Step 1: Complete the TrailBlazer EDI Vendor / Billing Service / Clearinghouse ID Request Form.

Step 2: Mail form to the following address:

MAILING ADDRESS	DELIVERY ADDRESS
TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 P.O. Box 100249 Columbia, SC 29202-3249	TrailBlazer Health Enterprises, LLC EDI Operations, AG-507 Building One 2300 Springdale Drive Camden, SC 29020-1728

Processing an EDI application will take **five business days** from the date of receipt. When processing is complete, you will receive a notification by e-mail (primary communication method), fax or mail. New electronic submitters and software vendors will be informed of any testing requirements.

EDI PROVIDER INFORMATION FORM

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 properly completing the application. Please follow these instructions closely. The Medicare Electronic Data Interchange Application is required. The Multiple Provider List should be used if you are listing additional providers on your application.

Form Field Name	Instructions for Field Completion

1. Provider Data	• Complete the date, provider's name, address, primary contact, phone, fax and e-mail address.
	• Indicate the National Provider Identifier (NPI) and Provider Number.
	• Indicate the Submitter ID if you are a direct submitter and are making an update.
	• EDI Transaction: Please indicate if you are enrolling for Electronic Claim Submission and/or Electronic Remittances.
	• Select the EDI Transaction requested.
	• The name of the provider (an authorized officer's name) must be printed in the space provided and that authorized officer's title and signature must also be included. The name and signature **must match** what is submitted on the EDI Agreement Form.
	• Action Requested: Please indicate appropriate request below:
	  • Provider is Submitter – Provider submits claims directly from their office
	  • Provider is with Billing Service/Clearinghouse

2. EDI Software Vendor Data	Indicate the name of the software vendor you will use for electronic claim submission to TrailBlazer. If you will use our free PC-ACE Pro32, write PC-ACE Pro32 in this field. If the vendor ID is known, enter the assigned ID; PC-ACE users may leave this field blank.
3. EDI Billing Service/ Clearinghouse Data	Indicate the name, primary contact, phone, fax and Submitter ID of the billing service or clearinghouse that will be communicating with TrailBlazer.

TrailBlazer HEALTH ENTERPRISES, LLC

EDI Provider Information Form

1. Provider Data (To be completed by provider)	Date:
Name:	
Address:	
City, State, ZIP:	
Primary Contact:	
Phone Number:	Fax Number:
E-mail Address:	
Please Check One: ☐ Part A Provider ☑ Part B Provider	
Please Check Applicable State: ☐ CO ☐ NM ☐ OK ☐ TX ☑ VA	
NPI (National Provider Identifier):	Provider Number:
Submitter ID (if available):	

I certify that I am legally empowered to sign this form on behalf of the Legal Business Name identified on this form. I acknowledge that in signing this, I bind this company or unincorporated organization to notify the Medicare contractor in advance and in writing if changes have occurred to information reported in this form or if it is necessary to revoke any designations made in the form. I certify that the information I have supplied is accurate. As a Medicare provider/supplier, I understand that in signing this form I am responsible for payment of any fees for EDI services charged by a designated EDI submitter/receiver with whom I have elected to conduct business. I also understand that any acknowledgement, error reports, or query responses related to submitted transactions will be returned to any designated EDI submitter/receiver with whom I have authorized on this form and that Medicare contractors are not permitted to send duplicate copies of outbound transactions to my organization as well as to the designated EDI submitter/receiver.

Signature_____ **Printed Name** _____

Title **Date**

Action Requested:

☐ Provider is Submitter (Provider submits claims directly from their office)

☑ Provider is with Billing Service/Clearinghouse (Section 3 must be completed)

2. EDI Software Vendor Data (To be completed by vendor)	
Company Name: Office Ally	
Primary Contact: Customer Service	Phone: 866-575-4120 opt.1
Vendor Code:	Fax: 360-896-2151

3. EDI Billing Service/Clearinghouse Data (To be completed by billing service/clearinghouse)	
Company Name: Office Ally	
Primary Contact: Customer Service	Phone: 866-575-4120 opt.1
Submitter ID: RR3426	Fax: 360-896-2151

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 contactor 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; and
   - 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 or 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 the Social Security Act (the Act);

14. That it will research and correct claim discrepancies;

15. That it will notify the carrier, MAC or FI or other contractor if designated by CMS within two 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's 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 two 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's Name: _____

Address: _____

_____

City/State/Zip: _____

Phone: _____

Authorized Signature: _____

By (Print Name): _____

Title: _____

Date: _____ Medicare Provider Number _____

National Provider Identifier (NPI): _____

Complete ALL fields above and mail entire agreement (three pages) with ***original*** signature to:

TrailBlazer Health Enterprises, LLC
EDI Operations, AG-507
P.O. Box 100249
Columbia, SC 29202-3249

Electronic Data Interchange (EDI) Provider Change Form

Check one: ☐ Part A ☑ Part B

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

Required fields are noted with an asterisk (*).

* 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: Office Ally, LLC

Submitter ID of Billing Service/Clearinghouse (if available): RR3426

Begin Date (if applicable): _____

Please mail the completed form to:

TrailBlazer Health Enterprises, LLC
EDI Operations, AG-507
P.O. Box 100249
Columbia, SC 29209-3249

If you have any questions, please contact the TrailBlazer Technology Support Center at (866) 749-4302.

TrailBlazer HEALTH ENTERPRISES, LLC

Published December 2008

CMS CENTERS for MEDICARE & MEDICAID SERVICES

INSTRUCTIONS – MR018

HOW LONG DOES PRE-ENROLLMENT TAKE?

- Standard processing time is approximately 4 weeks

WHERE SHOULD I SEND THE FORMS?

- Mail the forms to:

  MD Resource Solutions Inc.
  501 Cedar Road, Suite 2C
  Chesapeake, VA 23322

WHO CAN SIGN THE FORMS?

- Forms should be signed by the provider or person with signature authorization

WHAT FORMS SHOULD BE COMPLETED?

- Complete the following two forms if the provider has never submitted electronically to Railroad Medicare
  - Railroad Medicare Information Form
  - Railroad Medicare EDI Enrollment Agreement form

BOTH FORMS MUST BE COMPLETED

- Complete the following form if the provider has submitted electronically to Railroad Medicare and is just transferring to Office Ally
  - Railroad Medicare Change Form

HOW DO I CHECK STATUS?

- To check status, call Medicare at 866-749-4301 and ask if provider number has been linked to Office Ally, submitter number RR3426
- If it has been linked, you MUST notify Office Ally prior to submitting claims

WHAT PROVIDER NUMBER DO I USE?

- Forms must contain a valid Railroad Medicare Provider Number
- Can I use my tax ID, NPI, or State Medicare Number instead?
  - No – you may only use a valid Railroad Provider number. If you don't know your Railroad Provider number, call Railroad at 877-288-7600 or 866-749-4301
  - If your Railroad number is pending, you must wait until it is assigned before completing this form

I'M A GROUP – DO I LIST EACH DOCTOR'S PROVIDER NUMBER?

- No, if you have a group number, list only the group name and group number on your application
- If you have multiple group numbers, you must complete an entire application

Palmetto GBA
PARTNERS IN EXCELLENCE

Railroad Medicare EDI Information Form

Mail Completed Form To: Railroad Medicare EDI
PO Box 10066
Augusta, GA 30999

☐ **New Request** ☐ **Update Info**
Current Date: _____

Check One: ☐ Vendor ☐ Billing Service ☐ Submitter ☐ 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):

Check One: ☐ Provider is Submitter (Provider submits claims directly from their office. Fill out Part B below.)
☐ Provider is with Billing Service/Clearinghouse (Fill out Part C below.)

Request Electronic Remittances (ANSI 835 v4010A1): ☐ No
☐ Yes (must complete Addendum to Electronic Remittance Enrollment Form for Billing Services and Clearinghouses form)

PART B – EDI SOFTWARE VENDOR DATA

Check here if you will be using PC-ACE Pro32 Software provided by Palmetto GBA: ☐

Vendor Name:

Contact: **Phone:** ( ) **Ext:** **Fax:** ( )

Address:

City, State, Zip:

Vendor ID: **E-mail:**

Response Format: ☐ File ☐ Report Format **Mode:** ☐ ASYNCH ☐ CONNECT:Direct ☐ FTP

Data Compression: ☐ PKZIP (Version 2.04g or compatible) ☐ UNIX ☐ None

PART C – EDI BILLING SERVICE/CLEARINGHOUSE DATA
(TO BE COMPLETED BY BILLING SERVICE/CLEARINGHOUSE)

Company Name: Office Ally

Address: P.O. Box 872020

City, State, Zip: Vancouver, WA 98687

Submitter ID: RR3426 **E-mail:** info@officeally.com

Contact: Customer Service **Phone:** (866-575-4120 **Ext:** **Fax:** (360-896-2151

Response Format: ☐ File ☐ Report Format **Mode:** ☐ ASYNCH ☐ CONNECT:Direct ☐ FTP

Data Compression: ☐ PKZIP (Version 2.04g or compatible) ☐ UNIX ☐ 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, MAC s, 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: _____

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

X 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:		
	X 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: Office Ally

Submitter ID of Billing Service/Clearinghouse (if available): RR3426

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.

TRICARE (North and South) PRE-ENROLLMENT INSTRUCTIONS – CH002

THE TRICARE NORTH REGION IS ADMINISTERED BY HEALTH NET FEDERAL SERVICES AND INCLUDES CONNECTICUT, DELAWARE, ILLINOIS, INDIANA, KENTUCKY, MASSACHUSETTS, MARYLAND, MAINE, MICHIGAN,NEW HAMPSHIRE, NEW JERSEY, NEW YORK, NORTH CAROLINA, OHIO, PENNSYLVANIA, RHODE ISLAND,VERMONT, VIRGINIA, WASH D.C., WEST VIRGINIA AND WISCONSIN.

THE TRICARE SOUTH REGION IS ADMINISTERED BY HUMANA MILITARY HEALTHCARE SERVICES AND INCLUDES ALABAMA, ARKANSAS, FLORIDA, GEORGIA, LOUISIANA, MISSISSIPPI, OKLAHOMA, SOUTH CAROLINA, TENNESSEE, AND TEXAS

HOW LONG DOES PRE-ENROLLMENT TAKE?

- You may start submitting claims immediately

WHERE SHOULD I SEND THE FORMS?

- Mail the forms directly to:
  Tricare PGBA, LLC Government Programs
  EDI Dept FC_DEC
  PO Box 202007
  Florence, SC 29502-2007

WHO CAN SIGN THE FORMS?

- Forms should be signed by the provider or someone the provider has authorized to sign

ORIGINAL SIGNATURE IS REQUIRED!

WHAT FORM SHOULD I DO?

- CHAMPUS Pre-Enrollment Form

HOW DO I CHECK STATUS?

- There is no need to check status; you may start transmitting your claims immediately. Office Ally's submitter number is 98366.

WHAT PROVIDER NUMBER DO I USE?

- List your tax ID and NPI and SSN number where indicated.

ELECTRONIC DATA INTERCHANGE (EDI) PROVIDER TRADING PARTNER AGREEMENT

The provider agrees to the following provisions for submitting TRICARE claims electronically to Palmetto Government Benefits Administrators (PGBA, LLC).

A. The Provider Agrees:

1. That it will be responsible for all TRICARE claims submitted to PGBA, LLC by itself, its employees, or its agents.

2. That it will not disclose any information concerning a TRICARE beneficiary to any other person or organization, except PGBA, LLC and/or its contractors, without the express written permission of the TRICARE 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 TRICARE, or as required by State or Federal law.

3. That it will submit claims only on behalf of those TRICARE 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. For eligibility transactions, eligibility does not indicate authorization for services. Please follow TRICARE program procedures to obtain authorizations.

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 Department of Defense 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, Federal regulations, and TRICARE guidelines.

6. That it will ensure that all claims for TRICARE primary payment have been developed for other insurance involvement and that TRICARE 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 TRICARE claim for a period of at least 7 years after the bill is paid.

9. That it will affix the PGBA, LLC assigned unique identifier number of the provider on each claim electronically transmitted to the contractor.

10. That the PGBA, LLC 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 TRICARE program, and that any one 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 TRICARE beneficiaries, or any information obtained from TRICARE 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 S1106(a) of the Act).

14. That it will research and correct claim discrepancies.

15. That it will notify PGBA, LLC within 2 business days if any transmitted data are received in an unintelligible or garbled form.

16. Transmission Format. All standard transactions, as defined by Social Security Act § 1173(a) and the Transaction Rules, conducted between PGBA, LLC and Trading Partner or Business Associate, will only use code sets, data elements and formats specified by the Transaction Rules and the then current version of the PGBA, LLC Supplemental Implementation Guides. The PGBA, LLC Supplemental Implementation Guides and any updates or amendments thereto may be accessed at, www.mytricare.com, and are incorporated herein by reference. This section will automatically amend to comply with any final regulation or amendment to a final regulation adopted by HHS concerning the subject matter of this Section upon the effective date of the final regulation or amendment.

B. Palmetto Government Benefits Administrators Agrees To:

1. Provide an acknowledgment of claim receipt. The acknowledgment will consist of a Claims Submission Summary Report and the Error Claims Summary Report. These reports will be provided to the direct submitter of the claims files.

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 TRICARE'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 TRICARE electronic billers have equal access to any services that TRICARE requires TRICARE 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 TRICARE Management Activity (TMA) 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 TRICARE claims are submitted to PGBA, LLC. Either party may terminate this arrangement by giving the other party (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 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.

I have agreed to the above by signing below on this _____ day of _____, in the year of _____.

_____
Provider Name (please print)

_____
Provider(s) Tax ID Number

_____
National Provider Identification Number (NPI)

_____
Address

_____
City State Zip Code

_____
Authorized Signature and Title

_____
E-mail address

_____
Contact Name

Office Ally
Billing Service Name/Vendor

_____
Address

_____
City State Zip Code

Mailing Address:
Office Ally
PO Box 872020
Vancouver, WA 98687

If you are a group practice, please list the TRICARE provider numbers assigned by PGBA, LLC and attach to the TRICARE EMC Agreement. List the entity's name, and service/physical address and state. (Make additional copies if needed)

Provider # (with three digit suffix	Name	Address	City	State	Zip Code

TRICARE

WPS-TRICARE
1717 W. Broadway
P.O. Box 8128
Madison, WI 53708

Dear TRICARE for Life Provider:

Thank you for choosing electronic submission for your healthcare claims. WPS Insurance Corporation requires that all new electronic providers/groups sign, and have on file, a "Provider Agreement to Submit Electronic Media TRICARE for Life Claims" prior to claims submission. We request that you complete and return the agreement form, including this cover letter, to our office. *This TRICARE EDI Agreement is for* ***TRICARE for Life*** *providers.* "TRICARE For Life (TFL) is TRICARE's Medicare-wraparound coverage available to *all* Medicare-eligible TRICARE beneficiaries, regardless of age, provided they have Medicare Parts A and B."

An organization that has several providers can execute a single Provider Agreement form on behalf of the group. Only one authorizing individual is needed to sign the agreement for a Clinic/Group. However, we do need a complete list of all locations and providers for which you will be billing. Please include this as an attachment. In addition to the agreement, the following information is needed (please print):

NPI Organizational number:	**NPI Individual number:**	
Billing Provider Name:		
Claim type (select one or both);	☐ **Professional** ☐ **Institutional**	
Contact name:	**Phone number:**	**Fax number:**
Contact e-mail address: (Required)		
Service Facility Locations(s):		
NOTE: If you have multiple service facility locations, please attach a list including the associated billing address & NPI for each		

Please specify your EDI submission option:

☑ **Name of Clearinghouse or Billing service** (if applicable): Office Ally, LLC

☐ **Direct Filing via WPS Bulletin Board System or WPS Secure-EDI website Internet Batch.**

- If this option is selected, please register as a submitter through the WPS Trade Partner System (WTPS) at **https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do.**
- If you have already registered as a submitter, please provide the submitter number assigned _____.
- If you need assistance with registration, please contact WPS Electronic Data Services at 800-782-2680, option 4.

**Please note*: A faxed, e-mailed faxed image, or original will be accepted. Please mail, fax or e-mail your completed agreement to:

WPS Electronic Data Services
WPS Insurance Corporation
P.O. Box 8128
Madison, WI 53708-8128
Fax (608) 223-3824
E-mail Address: edi@wpsic.com

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For Office Use Only

Tax ID._____ _____ _____, _____ _____, _____ _____,

Sub # _____ CH _____ Direct _____

Net after 9/1/06 _____ Access Database _____ ALS _____ App Dt _____

Orig Sub # _____ New Sub # _____ Memo _____ ERAU _____ Initials_____

WPS

PROVIDER AGREEMENT TO TRANSMIT
ELECTRONIC MEDIA TRICARE FOR LIFE CLAIMS TO
WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION

For purposes of the United States Department of Defense's TRICARE health care program ("TRICARE"), Wisconsin Physicians Service Insurance Corporation (hereinafter referred to as "WPS"), and the undersigned health care provider (hereinafter referred to as "Provider"), acknowledge that each has entered into an agreement concerning the electronic transmission and submission of health claims to WPS and that this agreement is necessary for the implementation of these agreements. The terms set forth herein govern the relationship between WPS and the Provider in their performance of the above referenced agreements.

TERMS AND CONDITIONS

1. In transmitting Electronic Media Claims ("EMC"), Provider will transmit such claims edited and formatted according to the specifications indicated within the most current ANSI X12 837 WPS-TRICARE Companion Guide supplied by WPS. Provider understands the WPS EMC Companion Guide is proprietary and is authorized for use only by Provider and its employees working on its behalf to transmit such EMC and that any other use or distribution of the WPS EMC Companion Guide is strictly prohibited without the express written consent of WPS. WPS shall be the final authority in resolving any disputes about how electronic data shall be submitted.

2. Provider agrees that each and every claim submitted via electronic media, for all legal and other purposes, will be considered signed by the Provider or Provider's authorized representative.

3. Provider agrees to maintain a patient signature file. Provider understands WPS may validate through file audits, those claims submitted via electronic media which are included in any quality control or sampling method requested by WPS. Provider understands if no signed authorization is on file, an authorization must be obtained by the Provider from the patient prior to EMC submission to WPS.

4. In accordance with its contract with the TRICARE contractor, WPS will transmit the claims of health care providers in medium and format acceptable to appropriate TRICARE Managed Care Support Contractor and will return reports/electronic remittance to the Provider if requested by Provider. WPS may test any transmission against validity and consistency edits as defined in the WPS-TRICARE Companion Guide provided by WPS. Provider understands that WPS will accept all valid claims which meet such edit requirements and return errant transmissions for correction.

5. Provider acknowledges that WPS shall have no obligation with respect to the content of the information in claims either to verify, check or otherwise inspect the information supplied by the health care provider, except to reformat the claim data to the specifications required by the TRICARE Managed Care Support Contractor. Provider further acknowledges that TRICARE Managed Care Support Contractor is solely responsible for determining the completeness, accuracy and validity of the information and claims and that source documents for claims data are the responsibility of the health care provider.

6. There is no charge per claim to the Provider under this Agreement. WPS reserves the right to charge a per claim fee at a future date but would provide a 60 day notice of this change.

7. This Agreement may be terminated at any time by either party by giving at least five (5) days prior written notice of such termination to the other party. It will terminate automatically at the termination of either of the party's contract with the TRICARE contractor.

8. WPS shall not be liable or deemed in default for failure to fulfill any obligation under this Agreement due directly or indirectly to acts of God or public enemy, civil disorder, fire, flood, strike, or labor dispute, electrical failure, unavailability or shortage of electrical power, severe weather, regulations or acts of governmental agencies or instrumentalities, war or insurrection, mobilization of the armed forces, transportation, postal delay or any other causes beyond WPS' reasonable control.

9. All required and other notices under this Agreement and correspondence with WPS on technical systems matters shall be sent by Provider by certified mail, postage prepaid, return receipt requested to:

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
Madison, Wisconsin 53708-8128

If such notice is sent by WPS to the Provider, it will be addressed to the individual at the mailing address listed in the Provider signature space below.

10. This Agreement may not be modified or changed orally. All modifications must be in writing signed by both parties and must be consistent with the parties' obligations under their contracts with TRICARE contractor.

11. The interpretation and legal effect of this Agreement shall be governed by the laws of the State of Wisconsin. The parties agree that any legal proceedings arising out of this Agreement shall be brought in Dane County Circuit Court or United States District Court for the Western District of Wisconsin having jurisdiction over the matter.

12. This Agreement shall be binding upon, and inure to the benefit of the successors, assigns and legal representatives of each of the parties hereto. However, it shall not be assigned by either party without the written consent of the other party; such approval shall not be withheld unreasonably.

13. It is agreed that the relationship of the parties hereto is that of independent contractors and this Agreement does not constitute either party as agent, partner or employee of the other party.

14. WPS will hold harmless, defend and indemnify Provider against any liability, including cost of defense and settlements, imposed on Provider by law for any loss or damage arising from the negligent or intentional acts or omissions of WPS, provided that Provider has not caused such liability by Provider's own negligent or intentional acts or omissions.

    Provider will hold harmless, defend and indemnify WPS against any liability, including cost of defense and settlements, imposed on WPS by law for any loss or damage arising from the negligent or intentional acts or omissions of Provider, provided that WPS has not caused such liability by WPS' own negligent or intentional acts or omissions.

    As a condition to any indemnification hereunder, the indemnified party shall notify the indemnifying party in writing within ten (10) days after receipt of notice of any claim or suit against the indemnified party for which that party seeks indemnification hereunder and failure to so notify the indemnifying party shall relieve the indemnifying party from liability for indemnification. The indemnifying party shall be entitled to make such investigation, settlement or defense of the claim or suit as it deems prudent.

15. By executing this Agreement below, the parties agree to all of the terms and conditions of the Agreement. Provider further agrees to begin to transmit claims electronically to WPS only after Provider has received a written notice from WPS stating permission to do so has been granted.

_____	WISCONSIN PHYSICIANS SERVICE
Name of Provider	INSURANCE CORPORATION
_____	
Tax ID Number of Provider	
_____	
NPI Number of Provider	
_____	
_____	
Provider Mailing Address	
By _____	By _____
Signature and Title of Provider or Authorized Officer	*WPS Authorized Signature*
_____	_____
Date	*Date*