



## General Completion Instructions for “Florida New Installation/Change of Vendor Form”

Congratulations on your decision to submit claims electronically. To begin the process of submitting claims electronically, you are required to complete the appropriate forms.

This form will allow you to receive a sender number and mailbox password which allows you to access electronic applications. This form should be used in the situations listed below:

- Providers, Billing Services, Service Bureaus or Clearinghouses submitting paper claims that want to begin submitting claims electronically.
- Existing electronic senders that are changing software support vendors, formats or means of communication.
- Existing electronic providers that are using a billing service/service bureau or clearinghouse that are changing to submitting direct from the providers’ office to Florida Medicare.

**Note: If you are applying for the PC-ACE Pro32® Software, you are required to complete the Florida PC-ACE Pro32® Installation Package.**

The following sections outline how to complete the Florida New Installation Form and where to submit it. Please review this information carefully because **incomplete forms will be returned to the sender, which will delay processing.**

### **SECTION A1: Application Type - Claim submitter location should complete this section.**

**New Installation:** Check here if this is a new application. Complete the entire form if checked.

**Change of Vendor:** Check here only if changing software support vendors/companies, only complete sections A-C and fax to Florida Medicare EDI department at (904) 791-6692.

### **SECTION A2: Location Type - Claim submitter location should complete this section.**

**Provider/Supplier/Facility:** Circle if you are a provider, supplier or facility location applying to send claims electronically.

**Billing Service, Service Bureau or Clearinghouse:** If you are a billing service, service bureau or clearinghouse applying to send claims electronically, circle the appropriate name. **(You are required to have a provider signed up with you prior to receiving a sender number).**

### **SECTION B: Sender Location Information - Claim submitter location should complete this section.**

**Location Name:** Indicate name of location applying to submit electronic claims.

**Tax ID, SS or Health Industry Number (HIN):** Indicate Tax ID number or HIN of location applying to submit electronic claims. If a billing service/service bureau or clearinghouse, indicate the billing services’ Tax ID or SS number, not the providers’ you will be submitting claims for.

**Mailing Address:** The primary street address of the sender location transmitting claims. Please include any suite, apartment numbers or post office box numbers as appropriate.

**Contact Name/Position/Title:** Indicate the name/position/title of the person to be contacted in case of inquiries concerning electronic applications.

**Telephone/FAX Numbers/E-Mail Address:** Indicate fax, and phone numbers for contact person handling electronic application inquiries. Indicate the e-mail address for each contact person as appropriate.

**If location currently files automated claims, indicate sender number:** Indicate the sender number that the location currently submits electronic claims under. Even if your location has been assigned a sender number and it hasn't been used yet, you need to indicate that number. If using a billing service, service bureau or clearinghouse, indicate their sender number. If submitting a change of software support vendor, use existing sender number.

**Comments:** Indicate any special considerations or comments.

**SECTION C: Vendor Information - Software support vendor can assist with this section.**

**Company Name:** Indicate the name of the software support company that the provider location contracts with for electronic applications support.

**Mailing Address/City/State/Zip:** Indicate the complete physical address of the electronic application software support company.

**Contact Name:** Indicate the contact name at the software support company.

**Telephone/FAX Numbers/E-Mail Address:** Indicate fax, phone and e-mail numbers for contact person at your software support company handling electronic application inquiries.

**Comments:** Indicate if any special consideration or comments.

**SECTION D: Type Format:**

**FL Medicare B - 837 v. 004010X098A1**

**FL Medicare A - 837 v. 004010X096A1**

If you will be submitting each line of business (e.g., Florida Medicare A or Florida Medicare B) please note this on the form. You will be issued **one** sender number.

**SECTION E: Provider/Supplier/PA Group/Facility Numbers Information - Claim submitter location should complete this section.**

List all Provider Identification Numbers (PIN) that will be submitting electronic claims via this location. Ensure you indicate appropriate suffixes (if applicable) for each individual provider number and group members that will be submitted on your electronic claims.

**NOTE: If the Medicare Provider has an EDI Enrollment Form on file with Medicare EDI, no EDI Enrollment Form is required, and you may fax your Florida New Installation Form to (904) 791-6692 for processing. However, if the provider does not have an EDI Enrollment Form on file, you are required to submit both the Florida New Installation / Change of Vendor Form and the EDI Enrollment Form (signature is required).**

If additional individual provider locations or groups are added at any time in the future, complete and submit an additional EDI Enrollment Form indicating your sender number issued as the result of this application for Florida Medicare.

**Form Submission**

Fax or mail your completed applications to:

**Fax: (904) 791-6692**

**Mailing Address:**

Medicare EDI – FL Enrollment  
P. O. Box 44071 – 14T  
Jacksonville, FL 32231-4071

**Physical Address: (for Overnight or Express Mail)**

Medicare EDI – FI Enrollment  
532 Riverside Ave. 14T  
Jacksonville, FL 32202-4918



A CMS CONTRACTED INTERMEDIARY & CARRIER

MEDICARE

FLORIDA NEW INSTALLATION / CHANGE OF VENDOR FORM

To avoid delay in processing, please complete every section that applies. If you need assistance with this form, please contact your vendor.

SECTION A1. APPLICATION TYPE:

(Please Check One)

- \_\_\_ New Installation (sender number application)
(Complete entire form)
\_\_\_ Change of Vendor (Changing software support company)
(Only complete sections A-C)

SECTION A2. LOCATION TYPE:

(Please Circle One)

- Provider / Billing Provider / Facility /
Billing Service / Service Bureau /
Clearinghouse

SECTION B. SENDER LOCATION INFORMATION:

Location Name: \_\_\_\_\_

Tax ID, SS Number or Health Industry Number (HIN): \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ County: \_\_\_\_\_

Contact Name #1: \_\_\_\_\_ Position/Title: \_\_\_\_\_

Contact Name #2: \_\_\_\_\_ Position/Title: \_\_\_\_\_

Telephone #1 (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_ Telephone #2 (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_

FAX # (\_\_\_\_\_) \_\_\_\_\_ E-Mail Address \_\_\_\_\_

If location currently files automated claims, indicate sender #: \_\_\_\_\_

Comment(s): \_\_\_\_\_

SECTION C: VENDOR INFORMATION (The software support vendor can assist with this section)

Company Name: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_ County: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Position/Title: \_\_\_\_\_

Telephone Number: (\_\_\_\_\_) \_\_\_\_\_ EXT: \_\_\_\_\_ FAX# (\_\_\_\_\_) \_\_\_\_\_

Comment(s): \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

INTERNAL USE ONLY: DO NOT WRITE INSIDE THIS BLOCK

Production Sender Code: \_\_\_\_\_ Vendor Number: \_\_\_\_\_

Date Received: \_\_\_\_\_ Date Processed: \_\_\_\_\_

LOB Approved: [ ] FL Medicare Part A [ ] FL Medicare Part B

**SECTION D. TYPE FORMAT**

(Complete information within applicable line of business 1 or 2)

**1. Medicare A \_\_\_\_\_**

Λ American National Standards Institute (ANSI) 837 v. 004010X096A1

**2. Medicare B \_\_\_\_\_**

Λ American National Standards Institute (ANSI) 837 v. 004010x098A1

**SECTION E. PROVIDER/SUPPLIER/PA GROUP/FACILITY NUMBERS**

**GROUP OF PROVIDERS OR INDIVIDUAL PROVIDERS (not in group):** List all PA Group or individual provider numbers assigned by CMS/Medicare of Florida. **PLEASE INDICATE SUFFIX(ES) IF APPLICABLE.**

| <u>PA GROUP or<br/>Provider Number</u> | <u>Suffix</u> | <u>Provider Name (please print or type)</u> | <u>Line of<br/>Business</u> |
|--|---------------|---|-----------------------------|
| _____                                  | _____         | _____                                       | _____                       |
| _____                                  | _____         | _____                                       | _____                       |
| _____                                  | _____         | _____                                       | _____                       |
| _____                                  | _____         | _____                                       | _____                       |
| _____                                  | _____         | _____                                       | _____                       |

**NOTE:** If the Medicare Provider has an EDI Enrollment Form on file with Medicare EDI, no EDI Enrollment Form is required, and you may fax your Florida New Installation Form to (904) 791-6692 for processing. However, if the provider does not have an EDI Enrollment Form on file, you are required to submit both the Florida New Installation / Change of Vendor Form and the EDI Enrollment Form (signature is required).

If additional PA Groups or physicians for Florida Medicare will be submitting claims via this sender location at any time in the future, notify the Florida Medicare EDI Department by submitting a signed EDI Enrollment Form indicating your sender number.

**FAX OR MAIL COMPLETED FORMS TO:**

**FAX: (904) 791-6692**

**Mailing Address:**

Medicare EDI – FL Enrollment  
P. O. Box 44071 – 14T  
Jacksonville, FL 32231-4071

**Physical Address: (for Overnight or Express Mail)**

Medicare EDI – FL Enrollment  
532 Riverside Ave. 14T  
Jacksonville, FL 32202-4918

**QUESTIONS/CONCERNS:**

If you have any questions or concerns after reviewing the "Completion Requirements", please feel free to contact the Florida Medicare EDI Department (904) 791-8608 or Florida Medicare EDI Marketing/Operations (904) 791-8767, option 1.