The Medicare Enrollment Process at a Glance

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How to Enroll as a New Medicare Provider

There is a simple, **2-step** process to become enrolled as a Medicare provider. In order to submit claims to Highmark Medicare Services and receive reimbursements for services provided to beneficiaries in the states covered by Highmark Medicare Services, a specific form(s) must be completed.

Step 1: In order to determine which form(s) are necessary to complete your enrollment process, we are in the process of developing a reference table, which based upon your responses, will help better identify the appropriate form(s) that must be completed.

Step 2: Access the appropriate form(s). Complete and submit your forms with all supporting documentation. Once your forms have been received by Highmark Medicare Services, we will begin processing your enrollment application.

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Processing Timeframe

Submitting your completed enrollment form(s) is the first step to what we hope will be a positive relationship between you and Highmark Medicare Services. It is also an important process for ensuring proper claims payment, deterring criminal activity, and protecting the Medicare trust fund. It does take time to process your enrollment forms, so your patience in refraining from contacting us during that processing time is greatly appreciated.

Timeframes for processing provider enrollment forms are as follows:

Initial Enrollments and Reactivations
• **Paper Applications:** 60 – 180 calendar days from receipt
• **Internet-based (Web) PECOS Applications:** 45 – 90 calendar days from receipt
Change Requests
• **Paper Applications:** 45 – 90 calendar days from receipt
• **Internet-based (Web) PECOS Applications:** 45 - 90 calendar days from receipt

In order to avoid any delay in the processing of your enrollment form(s), please ensure all sections of the

enrollment form(s) are complete and any supporting documentation is sufficiently provided. Use the forthcomi Enrollment Form Reference Table to ensure you have completed the appropriate sections, and submitted the required documentation.

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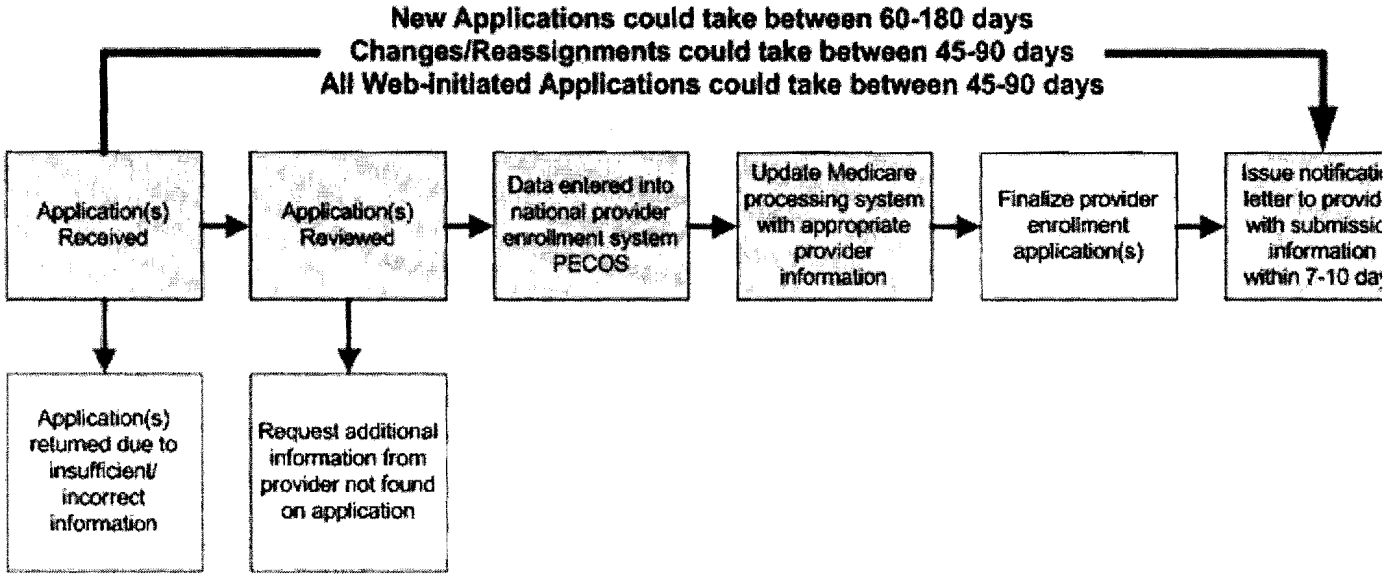
How Does an Application Get Processed?

You have completed and submitted the appropriate provider enrollment forms to Highmark Medicare Services. There are several different steps that must take place in order to process your enrollment or change application. Please review the following information in order to better understand the progression of work required to complete your request.



Most delays in processing enrollment application(s) are due to incomplete, inaccurate, or illegible information provided on the enrollment form(s) submitted. Use due diligence in completing the enrollment form(s) in order to avoid any processing delays.

Also, your prompt response in providing Highmark Medicare Services with enrollment form(s) corrections, addition information, and attachments will help reduce the processing time for your enrollment application(s).

STEP 1: Application Received and Initial Screening Performed

Once Highmark Medicare Services receives your provider enrollment application(s), you will receive an acknowledgement letter or a prescreening letter within 15 days. An internal application reference number will provided to you at this time.

Application Returned:

If your application(s) is not accepted for processing, it will be returned to you along with a letter indicating the reason for the return. Listed below are the top five reasons, identified by Highmark Medicare Services, that mi contribute to an application(s) being returned. Those reasons include:

- Applications received more than 30 days in advance of the effective date listed on the application (does no apply to Part A or Part B certified provider/ suppliers)
- Missing, unauthorized, or undated signatures – signatures must be originals and not copied or stamped

- Application not needed for transaction being requested
- Incorrect type of application submitted
- Application was submitted on an outdated form (the current version for this form is dated (02/08) and is available on our website in the Enrollment Center.

STEP 2: Application Reviewed and Development Initiated (If needed

CMS requires that all MAC contractors review each enrollment application in accordance with the Internet Only Manual (IOM) regulations. Many of the regulations that apply to the enrollment application are found in *IOM Publication 100-08, Chapter 10* and *IOM Publication 100-04, Chapter 1.*

During this review process, you may be contacted by a Provider Enrollment Representative to request missing information or ask for clarification of information (development). This additional information will be requested email, fax, or letter to the contact person provided on the application. This correspondence will provide an explanation of the information required to complete your application(s). In most cases, form corrections can b faxed to us. However, if a new signature, an additional form, or different form is needed, these forms will nee be completed and returned to us via mail. We recommend applications be completed in blue ink. You are allot 30 days from the date of the request to provide the additional information in the proper form. If the requestec information is not provided within that timeframe, the application(s) is rejected and you will need to resubmit a new application(s) and begin the enrollment process again.

NEW Provider Enrollment is introducing a new process for customers to use when responding to CMS-855 and CMS-588 development requests. This new process will improve the timeframe associated with delivery of development responses to HMS Credentialists and lessen the likelihood of misplaced documents. The majority HMS requests for development, whether faxed, emailed, or mailed to customers will now include the following form; the form cannot be downloaded. This form will be pre-populated with key identifiers that HMS will utilize electronically route development responses to Credentialists.

27053

CMS

Medicare

SAMPLE

Highmark Medicare Services

Provider Enrollment Development Response Fax Cover Sheet

FAX ALL REQUIRED DOCUMENTATION TO 1-877-439-5479

FAX LINE available 24 x 7

DO NOT USE ANY OTHER COVER SHEET

PART A ○ **PART B** ◉

Document Control Number (DCN) **Credentialist**

6 0 1 5 2 0 0 1 0 1 | 1 1 4

SAMPLE

Provider: John Smith MD

SAMPLE

HIGHMARK
Medicare Services

27065

The new form includes a toll-free number, **1-877-439-5479**. All development response information must be faxed to the new toll-free number with the Provider Enrollment Development Response Fax Cover Sheet as pag of the response.

To allow for additional efficiency in the CMS-855 development process, HMS requests that you supply an email address, if available, for either the Contact Person (Section 13) or Correspondence Address (Section 2B). This will allow us to email development requests to appropriate designated persons.

Validate Your Enrollment

If you are currently enrolled within the jurisdiction of Highmark Medicare Services and you have never submitt a CMS 855 Application or if the last application submitted was prior to November 2003, you will be required (under the IOM Publication 100-08, Chapter 10) to validate your enrollment by submitting a full 855 enrollmen application. The 855 enrollment validation application must be provided in order to being the initial enrollment request.

Independent Diagnostic Testing Facility (IDTF) Only

If you are enrolling as an IDTF, a site inspection will be scheduled once all of your information is received and validated. The inspection must take place before any further processing occurs on your application(s). Also, a an IDTF enrollee, Highmark Medicare Services will need to update the claim processing system with the code y have been approved to use for billing.

STEP 3: Data Entered into PECOS

Once any additional information requested has been received, Highmark Medicare Services will begin to enter t information provided on your enrollment form(s) into the national provider enrollment system, known as PECO During this phase of the provider enrollment process, you may be contacted again to verify information. For example, the system may fail to validate the name given versus the date of birth listed on the enrollment application. Whenever there is a validation error, you will be contacted to provide the correct information, otherwise we cannot continue with the enrollment process.

Ambulatory Surgery Centers (ASC) and Portable X-Ray Suppliers (PXS)

If you are a state certified ASC or PXS, your application will be sent at this time to the state for your survey. Once the survey is completed, CMS will forward Highmark Medicare Services a copy of your certification appro letter.

STEP 4: Update Medicare Processing System

Once all of the enrollment information has been incorporated into the Medicare processing system, additional information is then added in order for your claims to process accurately.

STEP 5: Finalization

Once the additional information has been entered into our processing system, the last step to finalizing your provider enrollment form(s) requires Highmark Medicare Services to verify the file information has posted correctly within the processing system.

STEP 6: Issue Notification Letter to Provider

Once we have confirmed the file information is set up correctly, you will receive a notification letter ("Welcome Letter") within 7-10 days after this finalization process is complete. This letter will provide you with valuable information regarding how you should be submitting Medicare claims.

Enroll as an Electronic Biller

Enrollment for Part A/B

Join Our Electronic Email Notification Network

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