CEDI Supplier Authorization Form

To: National Government Services, Inc.

I hereby request the Submitter and/or Receiver named below be allowed to perform the following functions on behalf of the DME supplier number(s) listed below (check all that apply):
EDI Transactions, i.e.,X12 Transactions and other types of files

__x__ Health Care Claim (837 v5010A1)
__x__ Health Care Claim Status Request & Response (276/277 v5010)
____ Health Care Claim Payment/Advice (835 v5010A1)
____ NCPDP Claims D.0

Submitter Information Request Date: 11/09/2015 **RID: 341133**

Entity Name:	ELIGIBLE, INC.		
Operating as a:	CLEARINGHOUSE		
Submitter ID:	B08078507		
Street:	1842 UNION ST		
City/State/Zip:	SAN FRANCISCO	CA	94123
Contact Name:	ELIGIBLE		
Contact Phone Number:	4152371679	**Ext:**	
Contact Email Address:	SUPPORT@ELIGIBLEAPI.COM		

DME Supplier Information

Supplier Name:	HEALTHIER SLEEP SOLUTIONS, LLC				
Street:	5 SHAWAN RD 2ND FLOOR				
City/State/Zip:	HUNT VALLEY	MD	21030		
Contact Name:	JOEL	NATHANSON			
Contact Phone Number:	4105279237	**Ext:**	410		
Contact Email Address:	HEALTHIERSLEEPSOLUTIONS@GMAIL.COM				
PTAN(s):	7374300001				
NPI(s):	1649676081				

IMPORTANT: This form must be signed, printed, dated and faxed to CEDI at 315-442-4299. Forms that are not printed, signed, dated and then faxed to the CEDI Department will not be processed. Requests received 30 days past the Signature date will be returned.

Authorized DME Supplier Name JOEL NATHANSON

Authorized DME Supplier Signature _____

Authorized DME Supplier Title OWNER **Date** _____

The person signing this form understands the DME supplier is responsible for the data received by the submitter and/or receiver. If the data is mishandled in any way, the DME supplier will be held responsible. The third-party is prohibited from viewing, storing, modifying, or reporting the data for their own use.

Signer of this form must be authorized to sign on behalf of the supplier, as reported to the National Supplier Clearinghouse. If you are unsure who your authorized official is, please contact the NSC at 866-238-9652.

Please attach additional sheets where necessary.
Additional sheets should be signed and dated.
MC9325 (11/01/2007)

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.

CMS EDI Enrollment Agreement

CMS EDI Enrollment Agreement

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 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 FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI, 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 FI, Carrier, RHHI, A/B MAC, CEDI, 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 FI, Carrier, RHHI, A/B MAC, DME MAC, CEDI, 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 FI, Carrier, RHHI, A/B MAC, DME MAC or CEDI (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 FI, Carrier, RHHI, A/B MAC, CEDI, 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, RHHI, A/B MAC, DME MAC, CEDI 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 FI, Carrier, RHHI, A/B MAC, CEDI, or other contractor if designated by CMS may require the provider to purchase any or all electronic services from the FI, Carrier, RHHI, A/B MAC, CEDI or from any subsidiary of the FI, Carrier, RHHI, A/B MAC, CEDI, other contractor if designated by CMS, or from any company for which the FI, Carrier, RHHI, A/B MAC, CEDI has an interest. The FI, Carrier, RHHI, A/B

MAC, CEDI, 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 FIs, Carriers, RHHIs, A/B MACs, CEDI, 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 sold directly, indirectly, or by arrangement by the FI, Carrier, RHHI, A/B MAC, CEDI, or other contractor if designated by CMS;

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 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.

C. Signature

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 (MAC name) on my behalf.

Submitter Information Request Date: 11/09/2015 **RID: 277554**

Medicare Supplier Name:	HEALTHIER SLEEP SOLUTIONS, LLC		
Contact Name:	JOEL NATHANSON		
Address:	5 SHAWAN RD 2ND FLOOR		
City/State/Zip:	HUNT VALLEY	MD	21030
Email Address:	HEALTHIERSLEEPSOLUTIONS@GMAIL.COM		
Phone Number:	4105279237	Ext:	
Submitter Type:	CLEARINGHOUSE		
Submitter ID:	B08078507		
Submitter Name:	ELIGIBLE, INC.		

PTAN(s)				
7374300001				
NPI(s)				
1649676081				

Authorized Signature: _____

Authorized Name: JOEL NATHANSON

Title: _____ **Date:** _____

This form must be signed, dated, and faxed to CEDI at 315-442-4299. Forms that are not signed, dated, and faxed to CEDI will not be processed.

Per CMS regulations, it is required to submit ALL pages of the EDI Enrollment Agreement. Failure to submit ALL pages may delay processing.

For further information, please contact the CEDI Help Desk at 1-866-311-9184

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