



51110



# EDI SPOT Enrollment Form for Third-Party Organizations



This option is for Billing Services or Clearinghouses that wish to have access to Medicare data via the internet. Please complete this form for enrollment to SPOT (Secure Provider Online Tool), First Coast Service Options' internet portal. All fields marked with \* are required and must be completed or the request will be rejected.

| *Third-Party Information |                       | R2-23 |
|--------------------------|-----------------------|-------|
| *Legal business name:    | *Nine-digit Tax ID #: |       |
| *Street address:         | *City:                |       |
| *State:                  | *Zip Code:            |       |
| *Website Address:        | Fax Number:           |       |

The Tax ID must match the Tax ID entered when creating the organization in the Identity Management (IDM) system.

| *Third-Party Contact Information    |             |                 |
|-------------------------------------|-------------|-----------------|
| *Technical Contact Name/Department: | *Telephone: | *Email Address: |
| *Marketing Contact:                 | *Telephone: | *Email Address: |

**Note:** The company name, marketing contact phone number, and marketing contact email address will be used for publication on the Approved Vendor List on the First Coast Service Options website, if requested below.

**Add to the approved vendor list on EDI's website:**      Yes      No  
*If nothing is selected, you will NOT be added to the list.*

## SPOT Information

This option is not available to vendors. This option is for Billing Services or Clearinghouses that wish to have access to Medicare data via the Internet. Users are encouraged to attach the [SPOT Migration List](#) with this form to request the conversion of multiple Provider Transaction Access Numbers (PTANs) from their current submitter ID to their SPOT submitter ID, rather than requiring each provider to complete a SPOT Enrollment form. You will be unable to log into SPOT until at least one provider is linked to your new submitter ID.

All SPOT Billing Service/Clearinghouse portal submitter ID's will be set up with the ability to submit 837 claim files through the portal.

By enrolling for SPOT, users agree to use an [approved software vendor](#) if sending batch files.

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## Type of Request

**\*Please choose your request type. Click only one:**

*If only requesting to send dental claims (837D transactions), complete the dental claims block below.*

|  |  |
|--|--|
|  | Assign a new SPOT portal submitter ID for 837 claim submission via SPOT.<br>I am a Billing Service      or Clearinghouse<br>(If nothing or both are selected, submitter will be setup as a billing service.)<br>A billing service collects the provider's claim information and creates the electronic claim files. A clearinghouse transfers EDI transactions for the provider. |
|  | I am currently using the existing SPOT portal submitter ID:<br>Other feature or contract additions only - indicate in the appropriate box below.   |

## Features

**What features do you support? Click all that apply:**

|  |   |
|--|---|
|  | Create ANSI ASC X12N 276 claim status files and receive ANSI ASC X12N 277 claim status files. |
|--|---|

## Dental Claims

**Optional: Only complete this block if you are requesting 837D dental claim transactions**

|  |   |
|--|---|
|  | Assign this third party a new/separate SPOT portal submitter ID for 837D claim files. |
|  | Add 837D to existing SPOT portal submitter ID:  |
|  | Assign 837D to the new SPOT portal submitter ID being requested with this form.       |

## Contracts

**\*What contracts do you support? Click only those that currently apply:**

|               |                      |               |                      |
|---------------|----------------------|---------------|----------------------|
| <b>Part A</b> | FL      PR      USVI | <b>Part B</b> | FL      PR      USVI |
|---------------|----------------------|---------------|----------------------|

## Approver Designation

Please designate the member(s) of your staff who should be the Billing Office Approver and Billing Office Back-Up Approver for your organization. We encourage you to select members of your staff who are knowledgeable and have tenure with the organization. **Do not complete this section with End User information.** End Users will request access through Identity Management (IDM).

I acknowledge that registration to the IDM system is required. Instructions for IDM registration will be included in your enrollment letter received upon completion of this enrollment request. Sharing of your IDM user ID will result in deactivation.

| * Approver Designation Contact Information |                            |                                |
|--|----------------------------|--------------------------------|
| *Approver First Name:                      | *Approver Last Name:       | *Approver Email Address:       |
| Backup Approver First Name:                | Backup Approver Last Name: | Backup Approver Email Address: |

The first and last names provided above must match the user's first and last names in the IDM registration for the corresponding roles.

**PC-ACE**

**\*Required: Select one**      Yes, enroll for PC-ACE      No, do not enroll for PC-ACE      I already have PC-ACE

**PC-ACE Enrollment is only needed if your office will be using the PC-ACE software to create claim files.  
When selecting to enroll, you are agreeing to the software terms listed below.**

- First Coast Service Options is authorized to distribute PC-ACE/PRINTLINK/ETRA (herein referred to as the "Program") to authorized users. PC-ACE and PRINTLINK software programs are copyrights of ABILITY. The Program is distributed for the purpose of creating electronic Medicare claim files only. Any use not authorized herein is strictly prohibited, including but not limited to, making copies of any part of the Program, reselling, or transferring copies to any party, or creating any modified or derivative work.
- The Program is provided "as is" without warranty of any kind, either expressed or implied, including but not limited to the implied warranties of merchantability or fitness for particular purpose.
- In no event will First Coast Service Options be liable for any loss or damage, including but not limited to incidental or consequential damages, arising out of the use or inability to use the Program even if First Coast Service Options has been advised of the possibility of such damages, or for any claim by any other party.
- The authorized user will upgrade this Program within 90 days of upgrade availability. This is a CMS requirement.
- The authorized user will provide the necessary office space, all electrical and telephone connections, hardware, telecommunication software and equipment that adhere to the technical requirements located on our [website](#).
- Internet download is the preferred method of software installation. Internet download instructions will be provided upon processing of this enrollment. There is no fee for software installation via Internet download. If you choose to receive the program in a CD-ROM format, contact Medicare EDI at 888-670-0940. Do not send payment with this request.

By enrolling, users agree to use an approved software vendor of [First Coast's 5010 approved vendor](#) to create the claim file sent through the SPOT claim submission feature.

**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 third party agent. The responsibilities and obligations contained in this document will remain in effect as long as electronic data interchange is being conducted with an A/B MAC, DME MAC or CEDI. Either party may terminate this arrangement by giving the other party (30) days notice of its intent to terminate. In the event that the notice is mailed, 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.

**Signature:** The signatory hereto represents and warrants that he/she is duly authorized to sign, execute, and deliver this Agreement on behalf of the party it represents for the Medicare Program 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 First Coast on my behalf.

**\*Required Signature**

|                                       |                                |
|---------------------------------------|--------------------------------|
| *Authorized Official Signature:       | *Date (mm/dd/yyyy):            |
| *Name of Authorized Official (Print): | *Title of Authorized Official: |

Carefully follow the [block-by-block instructions](#) for completing this form. Then email, fax or mail a signed version of the completed form using the information below.

**Email:** MedicareEDI@fcso.com

**Fax:** (904) 361-0470

**Mail:** First Coast Medicare EDI,

P.O. Box 3703

Mechanicsburg, PA 17055-1861

**Allow two weeks for processing. Please do not send duplicate forms.**