Medicare Plans Offering Part D Prescription Drug Benefit
Electronic Data Interchange (EDI) Agreement

The eligible organization, agrees to the following provisions for submitting PDE data, electronically to CMS.

A. The Eligible Organization Agrees:

That it is responsible for all Medicare PDE data submitted to CMS by itself, its employees, and/or its agents. That it must use adequate security procedures to ensure that all transmissions of documents are secure and protect all beneficiary-specific data from unauthorized access, as required by the HIPAA Security regulations (45 C.F.R Parts 160 and 164, subparts A and C)

That it shall establish and maintain procedures and controls so that information concerning Medicare beneficiaries, or any information obtained from CMS or its contractor, shall not be used by the eligible organization, its employees or agents, except as provided by the contractor and in compliance with all applicable State and Federal laws.

That the Secretary of Health and Human Services (HHS), a contractor, or contractors designated by HHS; has the right to inspect, audit and confirm information submitted by the eligible organization and shall have access at all reasonable times, to all original source documents related to the eligible organization's submissions, including the beneficiary's authorization and signature.

That it must affix the CMS-assigned unique identifier number (Submitter ID and Contract Number) of the eligible organization on each PDE file electronically transmitted to CMS. Affixing the CMS-assigned unique identifier number constitutes the eligible organizations' legal electronic signature.

That it must ensure that every electronic entry can be readily associated and identified with an original source document (e.g. an original drug claim). That it must retain all original source documentation pertaining to any such particular Medicare prescription drug event for a period of at least 10 years after the prescription drug event is received and processed.

That it shall research and correct PDE discrepancies in the event that a record or file is rejected or found to be in error.

That it shall notify CMS or its designated contractor within 2 business days if the eligible organization receives any data from that contractor or CMS in an unintelligible or garbled form.

That the eligible organization shall complete certification testing of the PDE data according to the specifications published by CMS. Failure to maintain certification standards may result in revocation of certification status.

B. The Centers For Medicare & Medicaid Services Agrees To:

Transmit to the eligible organization an acknowledgement of PDE receipt, if requested. Affix the Submitter ID and File ID on each response/report sent to the eligible organization.

Permit all Medicare eligible organizations to have equal access to any services that CMS requires Medicare contractors to make available to eligible organizations, regardless of the electronic billing technique or service they choose.

Notify the eligible organization within 2 business days if it receives any electronic data from the eligible organization 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 CMS under this document.

CMS may suspend or revoke authorization to submit PDE data at any time if the eligible organization fails to abide by the terms of this Agreement.

C. Signature:

By signing below, the eligible organization certifies that each submission of PDE data pursuant to this Agreement will be accurate and complete to the eligible organization's best knowledge, information and belief.

I am authorized to sign this document on behalf of the eligible organization, doing business as the Eligible Organization, and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Eligible Organization Name: _____

_____

Contract Number: _____

Signature: _____

Name: _____

Title: _____

Address: _____

_____

City/State/Zip: _____

Phone: _____

Email: _____

Date: _____

cc: Regional Offices

Please retain a copy of all forms submitted for your records. Complete and mail this form with original signature to:

PDE EDI Agreement
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