

**IOWA BLUE DENTAL - WELLMARK  
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CBIA1 (FEP Claims Only) CBIA2</b>
<p><b>ELECTRONIC REGISTRATIONS</b></p> <p>Agreements Required</p>	<p><b>Emdeon Business Services Provider Enrollment Form</b></p> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul> <p><b>Electronic Transaction Enrollment Form</b></p> <ul style="list-style-type: none"> <li>• Fill in the Practice Management Software Vendor name, address &amp; phone number.</li> <li>• Fill in the Provider name, address &amp; phone number.</li> <li>• Fill in the Group NPI Provider Number &amp; each Individual Name and Rendering NPI Provider Number(s).</li> <li>• Sign and date at the bottom of the form (<b>REQUIRED</b>).</li> </ul> <p><b>Signature and Audit Agreement</b> <i><b>YOU NEED TO PHOTOCOPY &amp; FILL IN THIS PAGE FOR EACH PROVIDER NUMBER YOU ARE ENROLLING.</b></i></p> <ul style="list-style-type: none"> <li>• Fill in the Signature, the Provider Name, Address, Group NPI Provider Number, Rendering NPI Provider Number and Date.</li> </ul> <p><b>Authorization for Electronic Transactions Via Third Party</b></p> <ul style="list-style-type: none"> <li>• Please fill in all requested information.</li> </ul> <p><b>Change of Address Request</b></p> <ul style="list-style-type: none"> <li>• This form needs to be completed for any address change or company name change. Company name changes need to be accompanied by a letter on your company's letterhead stating the old name and current name.</li> </ul>
<b>SPECIAL NOTES</b>	<ul style="list-style-type: none"> <li>• The enrollment process takes approximately 1 week to complete.</li> <li>• Iowa Blue will only allow Providers who reside or practice in the state of Iowa to submit claims electronically.</li> <li>• Iowa Blue will NOT allow non-participating providers of the Wellmark BCBS Program of Iowa to submit claims electronically and must submit claims on paper.</li> <li>• If you are unsure of your status as a Wellmark BCBS of Iowa member, please call 800-407-0267.</li> </ul>



emdeon™

business services

220 Burnham Street • South Windsor CT 06074

Vox 888-255-7293 • Fax 860-289-0055

	<ul style="list-style-type: none"><li>Iowa Blue will not process your enrollment unless you have already obtained a Provider number. If you do not have a Provider number, please contact Provider Services at (800) 708-1342.</li></ul>				
<b>SEND REGISTRATION FORMS TO:</b>	<p>Please fax or mail completed forms to:</p> <p>Emdeon Business Services Attn: Provider Registration 220 Burnham Street South Windsor, CT 06074</p> <p>860-289-0055</p>				
<b>ENROLLMENT CONFIRMATION</b>	<ul style="list-style-type: none"><li>Enrollment will be coordinated between Emdeon Business Services and Iowa Blue Cross Blue Shield.</li><li>The enrollment process takes approximately 5-7 business days.</li></ul>				
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	<p>If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.</p>				
<b>CONTACT PHONE NUMBERS</b>	<table><tr><td>Iowa Blue Provider Enrollment</td><td>800-407-0267</td></tr><tr><td>Emdeon Business Services</td><td>888-255-7293</td></tr></table>	Iowa Blue Provider Enrollment	800-407-0267	Emdeon Business Services	888-255-7293
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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Iowa Blue Dental – WellMark – payer IDs CBIA1 AND CBIA2**

Provider/Organization Name: \_\_\_\_\_

Tax Identification or Social Security Number: \_\_\_\_\_  
*(Number that will be used to submit electronic claims)*

Software Vendor: \_\_\_\_\_

Group NPI Number: \_\_\_\_\_  
*(if applicable)*

Name	Rendering	NPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

City, State, Zip Code: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Date: \_\_\_\_\_

# ELECTRONIC TRANSACTION REGISTRATION FORM

Electronic Commerce Solutions  
636 Grand Avenue, Station 142  
Des Moines, IA 50309  
Toll Free 800-407-0267  
Fax 800-691-1038

**\*\* PROVIDER'S NPI MUST BE VALID AND REPORTED TO WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA OR SOUTH DAKOTA BEFORE YOU CAN REGISTER\*\***

Submitter Name: Claims Processing Service, Inc. dba Emdeon Business Services, Inc - Dental

Contact: Provider Enrollment Group Title: Customer Service Representatives

Phone: (888) 255-7293 Fax: (860) 289-0055

Submitter Address 1: 220 Burnham Street

Submitter Address 2: \_\_\_\_\_

City: South Windsor State: CT Zip Code: 06078

County: Hartford Email Address: dentalsupport@emdeon.com

Do you already have a submitter ID? (This is separate from your provider NPI) YES  NO

If yes, what is your Submitter ID? 704

**As a result of HIPAA regulations, we need to know if you provide clearinghouse services for electronic transactions.**

YES  NO

Please select a method for sending your electronic transactions: Internet Connection to INet (Web BBS)  or Dial-Up to INet

Will you be posting 835 transactions (Electronic Remittance Advice)? YES  NO  If "YES", please answer next question.

Do you have the capability to process 835 transactions (ERA)? YES  NO

If 835 transactions (ERAs) are to be received, deliver to the following submitter number: \_N/A\_

## Practice Management Software

Vendor Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

## Provider Information

Provider Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

**Lines of Business:** Blue Shield (Professional)  Blue Cross (Institutional)  Blue Dental   
Commercial

Group Provider NPI: \_\_\_\_\_

Individual Name(s) & NPI: \_\_\_\_\_

If additional space for provider NPIs and names is needed, please attach a list to this agreement.

For information on communications software to submit ANSI 837 electronic transactions please contact EC Solutions at 800-407-0267.

Please complete and sign the registration form. The signature (located at the bottom of the form) must be from a provider or an office administrator authorized to sign on behalf of the doctors or facility.  
Authorized Signature /Date (**REQUIRED**) \_\_\_\_\_

**SIGN HERE**

# SIGNATURE AND AUDIT AGREEMENT

We (I) hereby authorize Wellmark Blue Cross and Blue Shield, acting on their own behalf or as fiscal agents for the administration of Title XVIII in Iowa or as agents of Blue Dental Plan and Pharmacy Service Corporation access to patients' files to:

- 1) Verify that valid patient authorizations are received and maintained for claims submitted from the office, when applicable.
- 2) Verify the validity and accuracy of the claims submitted.

In submitting machine readable claims, WE (I) understand that WE ARE (I AM) certifying that the required patient signatures, or, where applicable, appropriate signatures on behalf of the patient, and required physician certifications and re-certifications (PSRO certifications where applicable) are on file and that anyone who misrepresents or falsifies essential claims information, may, upon conviction be subject to fine and imprisonment under Federal law.

In the event that payment information is returned in machine-readable form, WE (I) understand that this information will cover all claims paid to this provider NPI whether they were submitted on paper or in machine readable form.

- Patient Authorizations (signatures) are not required for non-patients.
- Please photocopy this page for each provider NPI you need to register.



Signed: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

National Provider Identifier (NPI): \_\_\_\_\_

Date: \_\_\_\_\_

# PROVIDER AUTHORIZATION FOR ELECTRONIC TRANSACTIONS VIA THIRD PARTY

I, \_\_\_\_\_, \_\_\_\_\_,  
(Administrator/Officer) (Title)

representing \_\_\_\_\_ submitter number \_\_\_\_\_  
(Provider Office Name) (Provider Submitter # if Applicable)

authorize Claims Processing Service dba Emdeon Business Services, Inc. - Dental,  
(Clearing House/Billing Service)

submitter number 704 to submit my electronic claims to INet  
(Clearing House/Billing Service Submitter #)

for the following provider NPIs and names: \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

If additional space for provider NPIs and names is needed, please attach a list to this agreement.

Provider Office Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**SIGN HERE**

(Signature of Administrator in Provider Office)

(Signed Date)

**Note: This box is only applicable if you currently receive Electronic Remittance Advices (ERA) or would like to receive ERA's in the future.**

I would like my ERA to go to my office.  
The submitter number for my office is: \_\_\_\_\_

**OR**

I would like my ERA to go to my Clearing House/Billing Service.  
Their submitter number is: \_\_\_\_\_

# SUBMITTER CHANGE OF ADDRESS REQUEST FORM

This forms needs to be completed for any address changes or company name changes. Company name changes need to be accompanied by a letter on your company's letterhead stating the old name and current name.

## **Old Information:**

Submitter Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

## **New Information:**

Submitter Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Contact Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_