



emdeon™

business services

220 Burnham Street • South Windsor CT 06074

Vox 888-255-7293 • Fax 860-289-0055

**HORIZON HEALTHCARE DENTAL SERVICES  
(NEW JERSEY BLUE CROSS BLUE SHIELD)  
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>22099</b>
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<b>Emdeon Business Services Provider Enrollment Form</b> <ul style="list-style-type: none"><li>• Please complete all requested information</li></ul> <b>Signature on File Dentist Authorization Form</b> <ul style="list-style-type: none"><li>▪ Fill in the following:<ul style="list-style-type: none"><li>▪ E-mail address (not required)</li><li>▪ Provider Name</li><li>▪ Address</li><li>▪ City, State &amp; Zip Code</li><li>▪ Telephone &amp; Fax Numbers</li><li>▪ Dentist License Number (state license number)</li><li>▪ NPI Number (Individual Rendering NPI Number)</li><li>▪ Organization Name (as filed with TIN Number)</li><li>▪ Tax Identification Number</li><li>▪ Practice Management Software</li><li>▪ Site Code (required for multiple location offices)</li><li>▪ Sign</li></ul></li><li>• Date</li></ul>
<b>SPECIAL NOTES</b>	<ul style="list-style-type: none"><li>▪ If the Provider has a change of Tax Identification Number, address, or telephone number, the Provider is required to fill out a <b><i>Provider Change Form</i></b>. You may get a <b><i>Provider Change Form</i></b> from Emdeon Business Services by calling 888-255-7293.</li></ul>
<b>SEND REGISTRATION FORMS TO:</b>	Emdeon Business Services Attn: Provider Enrollment 220 Burnham Street South Windsor, CT 06074  Or fax to: 860-289-0055





**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Horizon Healthcare Dental Services – payer ID 22099**

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

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

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

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

Name	Rendering NPI
_____	_____
_____	_____
_____	_____
_____	_____

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

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

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

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

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

## Signature on File Dentist Authorization Form Electronic Submission

Print, complete and mail this form to Professional Relations Department, Horizon Blue Cross Blue Shield of New Jersey – Dental Programs, 3 Penn Plaza East PP-03H, Newark, NJ 07105 or Fax to (973) 274-4154.

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

Dentist Name: \_\_\_\_\_

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

City/State/Zip: \_\_\_\_\_

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

Dentist License #: \_\_\_\_\_ NPI #: \_\_\_\_\_

Organization Name: \_\_\_\_\_

(as filed with Tax Identification Number)

Tax Identification Number: \_\_\_\_\_

Practice Management Software: \_\_\_\_\_ \*Provider Site ID: \_\_\_\_\_

(\*If submitting for more than one location -- Obtain from your Practice Management Software)

"I hereby certify that I will obtain each patient's duly executed authorization to submit claims or predeterminations to you before I transmit a manual or electronic claim to you for that patient. I further agree to maintain signed authorization in my patient record for at least four years from the date of the last claim I submit to you for that patient and to produce it to you for copying upon your request. I hereby authorize you to accept this form as my certification to you of the accuracy of all information contained in each claim or predetermination which I submit to you manually or electronically (for electronic claims, this includes those claims I submit directly to you or which re submitted with my identification code with a clearinghouse). For each such submission: (a) the fee reported to you shall be the usual fee I charge for those services; (b) the date of each service for treatment rendered shall be the date when the service was completed (except in the case of predeterminations); (c) the fee I submit to you as having been paid by any primary carrier will be the actual fee paid by the primary carrier, if one exists; and (d) all services shall have been necessary in my professional judgement. I hereby agree to notify you in writing within 60 days of my receipt of a claim or predetermination from you as to any discrepancy between the information I submitted to you electronically and the information contained in your payment notice or predetermination. I agree not to assert that I transmitted different information to you unless I have given you timely notice of the discrepancy. This certification and authorization will remain in effect until you have received my written notice addressed to your Director of Claims, Horizon BCBSNJ Dental Programs, 3 Penn Plaza East, PP03H, Newark, NJ 07105, that I have terminated authorization; it will remain in effect for all claims received by you through the date when you receive that written notice of termination."

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

**Note: Each dentist in the office rendering treatment and submitting claims must sign a separate authorization form for use of signature on file.**