



220 Burnham Street • South Windsor, CT 06074
 Vox 888-255-7293 • Fax 860-289-0055

Participation in Dental Electronic Remittance Advice (ERA) is limited to those provider's whose practice management software vendor is participating in ERA with Emdeon or to those provider's who have a Dental Provider Services (DPS) account. Please contact your software vendor to verify participation or register for a DPS account at www.emdeondental.com

BLUE CROSS OF IOWA
 FEP CLAIMS ONLY
 DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	CBIA2
ELECTRONIC REGISTRATIONS Agreements Required	<p>Emdeon Dental Provider Enrollment Form</p> <ul style="list-style-type: none"> • Please complete all requested information. <p>Electronic Transaction Registration Packet for Wellmark Blue Cross and Blue Shield</p> <ul style="list-style-type: none"> • Pg 1: Please complete the Practice Management Software and Provider Information, including your group and individual NPI provider IDs as appropriate. Supply an authorized signature. • Pg 2: Please sign and complete all requested information. • Pg 3: Please complete all requested information and sign.
SEND REGISTRATION FORMS TO	<p>Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Or Fax to: 860-289-0055</p>
ENROLLMENT CONFIRMATION	<p>ERA enrollments take approximately 14-21 business days for completion. Once complete, Emdeon Dental will notify the provider or their software vendor to expect to begin receiving ERAs from Blue Cross of Iowa for FEP only claims.</p>
CHANGING ELECTRONIC BILLING AGENTS	<p>If the Provider currently receives ERAs through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.</p>



220 Burnham Street • South Windsor, CT 06074
 Vox 888-255-7293 • Fax 860-289-0055

Participation in Dental Electronic Remittance Advice (ERA) is limited to those provider's whose practice management software vendor is participating in ERA with Emdeon or to those provider's who have a Dental Provider Services (DPS) account. Please contact your software vendor to verify participation or register for a DPS account at www.emdeondental.com

<p>DISCONTINUING ERA</p>	<p>Discontinuing ERA is a 2 step process.</p> <ol style="list-style-type: none"> 1. Deactivation <ol style="list-style-type: none"> a. Providers receiving ERAs via their Practice Management Software need to request deactivation from their software Vendors. Please call your PMS directly. b. Providers receiving their ERAs via an Emdeon DPS account need only ignore the ERA option when logging into the DPS. 2. Payer Un-enrollment <ol style="list-style-type: none"> a. Each payer has their own unique process to discontinue ERAs and return to paper Remittance Advice. Please follow the below steps for this payer. <p>If a provider wishes to stop receiving ERAs he must complete the Electronic Transaction Registration Form leaving the 835 box blank. The form is available at http://www.wellmark.com/e_business/provider/forms/fmsprovider.htm</p>				
<p>CONTACT PHONE NUMBERS</p>	<table> <tr> <td>EC Solutions billing and registration departments</td> <td>800-407-0267</td> </tr> <tr> <td>Emdeon Business Services Provider Enrollment</td> <td>888-255-7293</td> </tr> </table>	EC Solutions billing and registration departments	800-407-0267	Emdeon Business Services Provider Enrollment	888-255-7293
EC Solutions billing and registration departments	800-407-0267				
Emdeon Business Services Provider Enrollment	888-255-7293				



220 Burnham Street • South Windsor, CT 06074
Vox 888-255-7293 • Fax 860-289-0055

Participation in Dental Electronic Remittance Advice (ERA) is limited to those provider's whose practice management software vendor is participating in ERA with Emdeon or to those provider's who have a Dental Provider Services (DPS) account. Please contact your software vendor to verify participation or register for a DPS account at www.emdeondental.com

PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Blue Cross of Iowa - ERA payer ID CBIA2**

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: _____

Email Address: _____

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: 704

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: _____



(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: 704