



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](http://www.emdeondental.com)**

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

<b>PAYER ID NUMBER</b>	<b>CBIA2</b>
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<b>Emdeon Dental Provider Enrollment Form</b> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul> <b>Electronic Transaction Registration Packet for Wellmark Blue Cross and Blue Shield</b> <ul style="list-style-type: none"> <li>• Pg 1: Please complete the Practice Management Software and Provider Information, including your group and individual provider IDs as appropriate. Supply an authorized signature.</li> <li>• Pg: 2: Please sign and complete all requested information.</li> <li>• Pg 3: Please complete all requested information and sign.</li> </ul>
<b>SEND REGISTRATION FORMS TO</b>	<p align="center">Emdeon Business Services        220 Burnham Street        South Windsor, CT 06074        Attn: Provider Enrollment        Or        Fax to: 860-289-0055</p>
<b>ENROLLMENT CONFIRMATION</b>	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.
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	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.



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<b>DISCONTINUING ERA</b>	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 <a href="http://www.wellmark.com/e_business/provider/forms/frmsprovider.htm">http://www.wellmark.com/e_business/provider/forms/frmsprovider.htm</a>				
<b>CONTACT PHONE NUMBERS</b>	<table border="0"> <tr> <td><b>EC Solutions billing and registration departments</b></td> <td><b>800-407-0267</b></td> </tr> <tr> <td><b>Emdeon Business Services Provider Enrollment</b></td> <td><b>888-255-7293</b></td> </tr> </table>	<b>EC Solutions billing and registration departments</b>	<b>800-407-0267</b>	<b>Emdeon Business Services Provider Enrollment</b>	<b>888-255-7293</b>
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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 Number: \_\_\_\_\_
(If applicable)

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

Table with 3 columns: Name, Number, Rendering, NPI. Includes multiple rows for data entry.

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

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

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

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

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

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



## 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 number 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 number you need to register.

**SIGN HERE**

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

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

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

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

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

Assigned Wellmark Group Provider Number(s): \_\_\_\_\_

Assigned Wellmark Individual Provider Number(s) & Name(s): \_\_\_\_\_

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

Fax to EC Registration Department at: 800-691-1038  
or mail to:  
EC Solutions  
Attention: EC Registration Department  
636 Grand Avenue, Station 142  
Des Moines, IA 50309

# 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 Dental,  
(Clearing House/Billing Service)

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

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

If additional space for provider numbers 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: \_\_\_\_\_<sup>704</sup>

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or mail to:  
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Attention: EC Registration Department  
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