PAYER ID: SUBMITTER ID:

Emdeon ERA Provider Information Form

*This form is to ensure accuracy in updating the appropriate account

1 Provider Organization

Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	

2 Vendor *(Emdeon certified vendor used to submit files to Emdeon)*

Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					

3 Payer

Payer ID		
Group ID	Individual Provider ID	NPI ID

4 Confirmations

Send Emdeon Claim Confirmations To:	

Special Instructions:

- **All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.**
- **SUBMIT COMPLETED FORM TO:**
  Fax: (615) 231-4843
  Email: batchenrollment@Emdeon.com

EMDEON REVISION FORM DATE:

An Independent Licensee of the Blue Cross and Blue Shield Association

Electronic Transaction Registration Packet

S-53260 6/09

REGISTRATION INSTRUCTIONS

Please note that a valid provider NPI is required in order to complete the ANSI 837 Electronic Transaction Registration Form.

The registration form may be used to request a submitter number for submitting electronic claims using INet or to add a provider to an existing submitter number.

This registration form is applicable for Wellmark Blue Cross and Blue Shield, Blue Dental and applies to any of the following ANSI Transactions: 837, 835, 270, 276, 278 and 820. A different registration form needs to be completed for the ANSI 834 transaction.

- **Interchange Network (INet) Access**
  Do you wish to start submitting electronic claims using INet?
  In order to submit electronic claims through INet the ANSI 837 Electronic Transaction Registration Form must be completed. The Signature and Audit Agreement must also be completed. One Signature and Audit Agreement per provider NPI is required for electronic claim submissions. Individuals authorized to sign the Signature and Audit Agreement would include an office manager or office administrator with authority to sign for the provider, doctors or facility.

- **Add provider NPI(s) to your existing Submitter ID**
  Already submitting electronic claims through INet and simply wish to add a new provider(s) to an existing submitter ID?
  Current submitters of electronic claims through INet must complete the ANSI 837 Electronic Transaction Registration Form in order to register a new provider under an existing submitter ID. One Signature and Audit Agreement per provider NPI is required.

Once the registration form is completed:

- Fax the completed registration form to the EC Registration Department at **800-691-1038**.
- The registration process takes approximately 1 week to complete from the time the registration form is received by EC Registration Department.
- To start submitting electronic claims using INet, a security letter containing submitter ID, INet ID and INet Password Security will be mailed to the address listed on the registration form under "Submitter Address."
- To add a provider number to an existing submitter ID, an email will be sent from EC Solutions Registration Department to the person listed in the "Contact" field of the registration form. If an email address is not listed, a phone call will be placed. The email or call is to confirm the provider NPI(s) is ready to submit electronically.

SUBMITTER: refers to the party that will be sending the claims electronically to INet. This may be a billing service, clearinghouse, or provider.
PROVIDER: refers to the facility or physician providing the healthcare services. Please use the clinic name if different from the doctor's name.
VENDOR: refers to the company that supports your electronic claims submission software. If you design your own software, you are the vendor.

ELECTRONIC TRANSACTION REGISTRATION FORM

Electronic Commerce Solutions
PO BOX 9232, Station 142
Des Moines, IA 50306-9232
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: EMDEON
Contact: ENROLLMENT HELP DESK Title: ______
Phone: (866) 924.4634 Fax: (615) 231.4843
Submitter Address 1: 26 CENTURY BLVD SUITE 601
Submitter Address 2: ______
City: NASHVILLE State: TN Zip Code: 37214
County: DAVIDSON Email Address: PAYERREGISTRATION@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? 000011104
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 transaction (ERA)? ☐ YES ☐ NO
If 835 transactions (ERA) are to be received, deliver to the following submitter number: 000011104

Practice Management Software	**Provider Information**
Vendor Name: ______	Provider Name: ______
Address 1: ______	Address 1: ______
Address 2: ______	Address 2: ______
City: ______	City: ______
State: ______ Zip Code: ______	State: ______ Zip Code: ______
Phone: (____) ______	Phone: (____) ______

Line of Business: ☐ Blue Shield (Professional) ☒ Blue Cross (Institutional) ☐ Blue Dental ☐ Commercial

Group Provider NPI: ______

Individual Names(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)** ______ 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 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: ______/______/______

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
PO BOX 9232, Station 142
Des Moines, IA 50306-9232

PROVIDER AUTHORIZATION FOR ELECTRONIC TRANSACTIONS VIA THIRD PARTY

I, ______________________________, ______________________,
(Administrator/Officer) (Title)

representing ______________________________ submitter number ______________________
(Provider Office Name) (Provider Submitter # if Applicable)

authorize EMDEON ______________________________,
(Clearing House/Billing Service)

submitter number 000011104 ______________ 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: (_____)______________________

Email 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: 000011104

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
PO BOX 9232, Station 142
Des Moines, IA 50306-9232

SUBMITTER CHANGE OF ADDRESS REQUEST FORM

This form 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: (_____)____________________

Email Address: ______________________________

New Information:

Submitter Number: ______________________________

Facility Name: ______________________________

Contact Name: ______________________________

Address: ______________________________

City: ____________________ State: ____________ Zip Code: ____________

Phone: (_____)____________________ Fax: (_____)____________________

Email Address: ______________________________

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
PO BOX 9232, Station 142
Des Moines, IA 50306-9232

CANCELLATION REQUEST

☐ **Cancellation of Submitter ID Number:** ______________________
Submitter Number

The cancellation of a submitter number will cause the following capabilities to cease: submission of electronic claims, retrieval of all electronic reports, and retrieval of ERA files. Reactivation of a submitter number requires a new registration form to be completed and the registration process to assign a new submitter number. This will delay your ability to send your claims electronically. Canceling your submitter number does not automatically cancel your AT&T ID or the applicable AT&T charges. Not affected are your connections to the Wellmark Internet/Web applications or your connections to Cahaba.

☐ **Cancellation of PCA-AP Pro32 Software:**

The cancellation of your software will cease all support for that specific software that you have identified above. You will continue to have access to our INet system, unless you cancel your submitter number as identified above. There are no refunds! Electronic claims software media must be returned and removed from all computer systems. Along with this cancellation form we require a written statement on your company's letterhead stating the software is no longer being used.

☐ **Using Another Vendor:** ______________________
Name of New Vendor, Contact Name and Telephone Number

Electronic transactions will continue from our office via the vendor or clearing house identified above. The reports EC Solutions creates for your electronic claims are returned to the submitter number used when they are submitted. Assure yourself of the receipt of all your electronic reports from your previous vendor, as there may be claim rejections for you to rework.

To reinstate the above services, you must contact the EC Registration Department toll free at 1-800-407-0267.

Required Submitter Information:

Submitter Name: EMDEON

Address: 26 CENTURY BLVD SUITE 601

City: NASHVILLE State: TN Zip Code: 37214

Phone: (866) 824.4634 Fax: (615) 231.4843

Email Address: PAYERREGISTRATION@EMDEON.COM

Authorized Signature:

Authorized Signature: ______________________ Title: ______________________

Printed Name: ______________________

Date Signed: ____/____/____ Effective Date of Request: ____/____/____

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
PO BOX 9232, Station 142
Des Moines, IA 50306-9232