

PAYER ID:

SUBMITTER ID:



## Emdeon **Claims** Provider Information Form

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

<b>1 Provider Organization</b>					
Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
<b>2 Vendor</b> <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					
<b>3 Payer</b>					
Payer ID					
Group ID	Individual Provider ID		NPI ID		
<b>4 Confirmations</b>					
Send Emdeon Claim Confirmations To:					
Special Instructions:					
<ul style="list-style-type: none"> <li>All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.</li> <li>SUBMIT COMPLETED FORM TO:                      Fax: (615) 231-4843                      Email: <a href="mailto:batchenrollment@Emdeon.com">batchenrollment@Emdeon.com</a> </li> </ul>					
EMDEON REVISION FORM DATE:					



An Independent Licensee of the Blue Cross and Blue Shield Association

# Electronic Transaction Registration Packet

## 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? 10988

**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: 10988

**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: ( \_\_\_\_\_ ) \_\_\_\_\_

**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 10988 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: 10988

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