

PAYER ID:

SUBMITTER ID:



Emdeon **Claims** 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:	
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Special Instructions:

- All Payer Registration forms must contain original signatures, NO stamped signatures or photocopies are accepted.
- SUBMIT COMPLETED FORM TO:
 Emdeon
 Donelson Corporate Ctr Bldg 3
 3055 Lebanon Pike Ste 1000
 NASHVILLE, TN 37214-2230

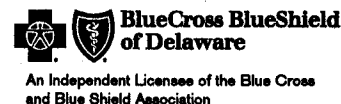
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EMDEON REVISION FORM DATE:



Blue Cross Blue Shield of Delaware • P.O. Box 1991 • Wilmington, DE 19899-1991

Phone: 302 421-8428
Fax: 302 421-8485
E-mail: emc@bcbsde.com
Web Site: www.bcbsde.com



Electronic Data Exchange Enrollment

Provider Name or Group Provider Number

Address (street, city, state and zip code)

Contact Person Telephone (include area code)

Adding to existing Submitter? [X] Yes [] No. If "Yes," Submitter Number: 112100069

EMDEON

Name of (check one): [] Software Vendor [X] Billing Service

3055 LEBANON RD., BLDG. 3, STE 200 NASHVILLE, TN. 37214

Address (street, city, state and zip code)

ENROLLMENT HELP DESK 1-800-845-6592

Contact Person Telephone (include area code)

If you are unable to answer any of the following questions, please contact your hardware/software vendor.

CLAIMS SUBMISSION

Modem Protocol (asynchronous only)

[] X modem [] Y modem [X] Z Modem [] ASCII

Transmission Format

[X] National Standard (NSF) Version: 1.03

OTHER SERVICES AVAILABLE (Check those desired.)

[X] Claims Status [] Eligibility and Benefits

[] Electronic Remittance Advice

In accordance with specifications set forth by Blue Cross Blue Shield of Delaware (The Corporation) for submission of automated claims, I / we agree that:

The Provider agrees to submit claims in accordance with the Participating Contract and in the format specified by The Corporation.

The Corporation agrees to accept and process claims submitted in accordance with this contract. Such processing and payment will be according to the terms of the Participating Provider Contract.

The Provider will ensure that every claim submitted can be readily associated and identified with the patient's medical and business office records. All medical records and source documents will be retained for a period of six (6) years after the month the bill was submitted. These records may be retained on microfilm.

The Provider agrees that the Corporation or its designee will have reasonable access to all documents pertaining to claims submitted via electronic media for the purpose of auditing and confirming the claims information submitted. Such access will be permitted to documents in the possession of the Provider, as well as the Provider's billing agent(s).

The Provider agrees that any overpayments which are discovered and brought to its attention will be refunded within thirty (30) days of the date of notification.

The Provider will research and correct any and all billing discrepancies caused by submission of automated claims.

The Provider /Corporation will maintain the confidentiality of passwords, preventing unauthorized users from committing data security violations with my log-on identification.

Signature of Health Care Professional or Authorized Representative

Title

Type or Print Name

Date

Please mail the signed original to: Blue Cross Blue Shield of DE, Attn: Electronic Claims (4-2-04), P.O. Box 1991, Wilmington, DE 19899.



Authorization Agreement for Direct Deposit Transactions

Provider Name: _____

Provider Number(s): _____

Address: _____

Bank Name: _____

Bank ABA Number: _____

Checking Account Number: _____

Office Contact and Phone Number: _____

The completion and signing of this form will give Blue Cross Blue Shield of Delaware (BCBSD) authorization to electronically credit the above account, effective within five (5) business days of receipt of the form by BCBSD.

- Please be advised that by completing this form, you are also authorizing BCBSD to electronically debit this account in the event there are overpayments or duplicate payments.
- Please notify us, in writing, if you decide you wish to be removed from the direct deposit credit process. It may take up to five (5) business days after receipt of your request payments to be sent as checks.

Should you have any questions regarding your direct deposit payments, please feel free to contact: **Andy Rumford at 302.421.8428.**

Authorized by: _____ Date: _____

Mail completed form to:
Blue Cross Blue Shield of Delaware
P.O. Box 1991
Wilmington, DE 19899-1991
ATTN: Andy Rumford 5-2-65

Fax:
ATTN: Andy Rumford
302.421.3265