

PAYER ID:

SUBMITTER ID:



emdeon™

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:	
<p>Special Instructions:</p> <ul style="list-style-type: none"> • 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 	
<p>EMDEON REVISION FORM DATE:</p>	

HUDSON HEALTH PLAN, INC.

ELECTRONIC DATA INTERCHANGE (EDI) SUBMITTER AGREEMENT & ENROLLMENT FORM

The Provider agrees to the following provisions as conditions of submitting claims electronically to Hudson Health Plan, Inc.

PROVIDER OBLIGATIONS

1. Responsibility for Claims. The Provider is responsible for the accuracy, truth and completeness of all claims submitted to Hudson Health Plan by itself, its employees, or its agents.
2. Confidentiality. The Provider will not disclose any information concerning a Hudson Health Plan member to any other person or organization, except under the following circumstances:
 - where the express written permission of the plan member or his/her parent or legal guardian has been given
 - where required for the care and treatment of a plan member who is unable to provide written consent
 - in order to bill insurance primary or supplementary to Hudson Health Plan
 - where required by Federal, State or local law
3. Authorization. The Provider will submit electronic claims only on behalf of those Hudson Health Plan members who have given their written authorization to do so, and will certify that the requisite signed authorizations are on file.
4. Security Procedures. The Provider will use sufficient security procedures to ensure that all transmissions of claims and documents are authorized and will protect all plan member specific data from improper access. The Provider will establish and maintain procedures and controls so that information concerning plan members, or any information obtained from Hudson Health Plan, shall not be used by agents, billing services, or employees for unauthorized purposes.
5. Original Source Documents. The Provider will ensure that every electronic entry can be readily associated and identified with an original source document. The Provider will retain all original source documentation and medical records pertaining to claims for plan members for a period of at least 7 years, or longer if required by law.

6. Required Elements of Claim. Each source document and claim will include the following information:

- Plan member name
- Plan member I.D. number
- Plan member date of birth
- Date(s) of service
- Diagnosis/nature of illness
- Procedure/service performed/modifiers,
- Charges
- Place of service

In addition, the Provider will include its Federal Tax I.D. Number on each claim. This Federal Tax I.D. Number constitutes the Provider's legal electronic signature and an assurance by the Provider that services were performed as billed.

7. Right to Audit and Access. The Provider agrees that Hudson Health Plan or its appointed designee has the right to audit and confirm information submitted by the Provider, and shall, upon request, have access to all original source documents and medical records related to the Provider's submissions, including the plan member's authorization and signature.

8. Adjustments. All incorrect payments that are discovered as a result of such an audit shall be adjusted according to the applicable regulations and HCFA guidelines. Any falsification or concealment of material fact may be prosecuted under application law.

9. Claim Discrepancies. The Provider will research and correct claim discrepancies.

10. Misrepresentations. The Provider acknowledges that all claims for plan members will be paid from government-funded programs, and that misrepresentation or falsification of such claims may, in the event of conviction, result in fines and/or imprisonment under applicable Federal and State law.

11. Coordination of Benefits. The Provider will ensure that all claims for Hudson Health Plan primary payment have been researched for other insurance involvement and that Hudson Health Plan is the primary payer.

12. Problems with Transmitted Data. The Provider will notify Hudson Health Plan within 2 business days if any transmitted data are received in an unintelligible or garbled form.

Hudson Health Plan Obligations

1. Acknowledgement of Claim Receipt. Hudson Health Plan will transmit to the Provider or clearinghouse an acknowledgement of claim receipt.
2. Identification Number. Hudson Health Plan will include its payer I.D./Carrier number, as the electronic signature, on each remittance advice sent to the Provider.
3. Timely Payments. Hudson Health Plan will ensure that payments to Providers are timely in accordance with the requirements of Federal and State law.
4. Problems with Transmitted Data. Hudson Health Plan will notify the Provider within 2 business days if any transmitted data are received in an unintelligible or garbled form.

Other Provisions

1. Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of New York, except where such laws are pre-empted by Federal law.
2. Term and Termination. This document shall become effective when signed by the Provider. The responsibilities and obligations contained in this document will remain in effect as long as electronic claims are submitted to Hudson Health Plan. Either party may terminate this arrangement by giving the other party (30) days written notice of its intent to terminate.
3. Notice. Any notices given regarding this Agreement shall be in writing, sent by certified mail, return receipt requested, or by overnight courier, with proof of receipt, and shall be effective on receipt.

Signature

I am authorized to sign this document on behalf of the indicated party and I have read and agree to the foregoing provisions and acknowledge same by signing below.

Provider's Name _____ License # _____

Title _____

Address _____

City/State/Zip _____ Phone # _____

Federal Tax I.D. Number(s) _____

By _____

(Signature)

Title _____

Date _____

INTERNAL USE ONLY

(Hudson Health Plan EDI Staff-Do not write below this line)

Date Received _____ Received By _____