

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 <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
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:					
<ul style="list-style-type: none"> 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:					

**HEALTHPLUS OF MICHIGAN, INC. AND ITS SUBSIDIARIES
BILLING AGENT/PRACTITIONER/PROVIDER ELECTRONIC BILLING AGREEMENT**

BILLING AGENT CERTIFICATION:

I HEREBY CERTIFY on behalf of EMDEON (billing company) that I have been authorized by practitioner/provider _____ (name of practitioner/provider) and have entered into a Business Associate Agreement as required by 45 CFR Parts 160 and 164 of the "Privacy and Security Rules" with practitioner/provider to bill HealthPlus of Michigan, Inc. and its subsidiaries (HealthPlus) with which the practitioner/provider participates through an EDI system for services provided to HealthPlus members/enrollees. I understand and agree to cooperate with the practitioner/provider contractual relationship with HealthPlus.

Billing agent/practitioner/provider agrees to conduct these transactions in accordance with the referenced Transaction Standards, the limitations set forth in this agreement and the HealthPlus EDI Companion Guide.

I understand that I have full responsibility for any errors or irregularities in claims submission as between HealthPlus and myself. I understand that I may terminate this Agreement at any time by giving at least thirty (30) days advance written notice to HealthPlus and HealthPlus may terminate this Agreement upon thirty (30) days advance written notice to Practitioner/Provider.

_____, 20____, 866.924.4634
Signature of Billing Agent Date Phone number of Billing Agent

I HEREBY AUTHORIZE EMDEON (name of billing company) to act as my billing agent for the purpose of transmitting electronic claims information to HealthPlus concerning services I provide to HealthPlus enrollees.

Signature of Practitioner/Provider Date

Practitioner/Provider Name (please print) HealthPlus Provider # _____

Address Practitioner/Provider Specialty

Phone # Vendor

BC/BS Billing Location Code (if BC/BS code not available, HealthPlus will assign a code) Password (3 to 8 characters)

Medicare Provider # UPIN # _____

NPI Number: _____ EDI Specialist Initials: _____

I. DEFINITIONS:

- A. **Electronic data Interchange or "EDI"**: means the computer-to-computer exchange of business information between HealthPlus and billing agent on behalf of practitioner/provider using the standard transaction formats (ANSI ASC X12). Because EDI differs from manual methods of data exchange, this Agreement is intended to resolve EDI specific issues not covered by any other agreements between HealthPlus and its practitioners/providers.
- B. **Transaction Standard(s)**: means transaction formats approved for general use by the American National Standards Institute (ANSI) Accredited Standards Committee (ASC) X12, and adopted by the Secretary of HHS, including the transactions rules set out in the Standards for Electronic Transactions, 45 C.F.R. Parts 160 and 162, as may be amended and modified from time to time. EDI standards for automated information systems include, but are not limited to, transaction sets, implementation guides, data dictionary, segments dictionary and transaction controls.