



emdeon™

Emdeon **Realtime** Provider Information Form

This form is to ensure accuracy in updating the appropriate account

1	Provider Organization			Customer #			
Practice/ Facility Name				Tax ID			
Provider Name							
Address				City/State			Zip Code
Contact Name							
E-mail Address				Telephone			Fax
MID				TID			TPG

2	Payer						
Payer Name/ID							
Group Provider ID				Individual Provider ID		Billing NPI	

3	Confirmations						
Send Emdeon 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: 							
Email: RTenrollment@emdeon.com Fax: 615.885.3713							

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EMDEON REVISION FORM DATE:							
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Electronic Transaction Registration Packet for Wellmark Blue Cross and Blue Shield

REGISTRATION INSTRUCTIONS

Please note that a valid provider number from Wellmark Blue Cross and Blue Shield of Iowa or South Dakota 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, Wellmark DME 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 number 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 number(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 number 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.
- For the requests 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."
- For the requests to add a provider number to an existing submitter ID, a phone call from EC Registration Department will be placed to the person listed in the "Contact" field at the phone number listed on the registration form. The call is to confirm the provider number(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.

Questions? Call Toll Free at 800-407-0267

ELECTRONIC TRANSACTION REGISTRATION FORM

Electronic Commerce Solutions
636 Grand Avenue, Station 142
Des Moines, IA 50309
Toll Free 800-407-0267
Fax 800-691-1038

****A VALID PROVIDER ID FOR WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA OR SOUTH DAKOTA IS REQUIRED TO REGISTER****

Submitter Name: EMDEON
Contact: MIR GROUP Title: ENROLLMENT
Phone: (800) 819-7963 Fax: (615) 885-3713
Submitter Address 1: 3055 Lebanon Pike
Submitter Address 2: _____
City: NASHVILLE State: TN Zip Code: 37214
County: DAVIDSON Email Address: Mir_request@emdeon.com

Do you already have a submitter ID? (This is separate from your provider number) YES NO

If yes, what is your Submitter ID? 11104

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 transactions (ERA)? YES NO

If 835 transactions (ERAs) are to be received, deliver to the following submitter number: _____

Practice Management Software

Vendor Name: EMDEON
Address 1: 3055 LEBANON PIKE
Address 2: _____
City: NASHVILLE
State: TN Zip Code: 37214
Phone: (800) 819-7963

Provider Information

Provider Name: _____
Address 1: _____
Address 2: _____
City: _____
State: _____ Zip Code: _____
Phone: () _____

Lines of Business: Blue Shield (Professional) Blue Cross (Institutional) Blue Dental
DME (Wellmark Only) Commercial

Assigned Wellmark Group Provider Number(s): _____

Assigned Wellmark Individual Provider Number(s) & Name(s): _____

If additional space for provider numbers 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)** _____

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 number 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 number you need to register.

Signed: _____

Provider Name: _____

Address 1: _____

Address 2: _____

City, State and Zip Code: _____

Assigned Wellmark Group Provider Number(s): _____

Assigned Wellmark Individual Provider Number(s) & Name(s): _____

Date: _____

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
636 Grand Avenue, Station 142
Des Moines, IA 50309

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 11104 to submit my electronic claims to INet
(Clearing House/Billing Service Submitter #)

for the following provider numbers and names: _____,
_____, _____, _____, _____.

If additional space for provider numbers and names is needed, please attach a list to this agreement.

Provider Office Name: _____

Provider Address: _____

City, State and Zip Code: _____

Phone: () _____ Fax: () _____

E-mail 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: _____

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
636 Grand Avenue, Station 142
Des Moines, IA 50309

SUBMITTER CHANGE OF ADDRESS REQUEST FORM

This forms 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: () _____
E-mail Address: _____

New Information:

Submitter Number: _____
Facility Name: _____
Contact Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone: () _____ Fax: () _____
E-mail Address: _____

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
636 Grand Avenue, Station 142
Des Moines, IA 50309

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: _____

Address: _____

City, State and Zip Code: _____

Phone: () _____ Fax: () _____

E-mail Address: _____

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: Registration Department
636 Grand Avenue, Station 142
Des Moines, IA 50309