



## CAREPLUS HEALTH PLAN ELIGIBILITY

### Realtime Cover Sheet

#### For Initial Enrollment with this payer:

- If you have NOT submitted eligibility transactions to this payer, Payer Registration forms ARE required by the Payer. Please complete all fields on the following page as well as the attached Payer Registration forms and return to WebMD for processing.
- This form does not require an original signature and can be faxed to the number below.
- Registration with this payer can take from 1-2 weeks.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid provider ID will delay the process.

#### Instructions for submitting Realtime Forms:

- You must include this page when submitting Payer Registration forms to WebMD
- Registration forms must be submitted to the address or fax number below  
To obtain forms or additional payer information, visit our website: <http://www.webmd.envoy.com>

<b>This Registration form is for a:</b>			
<input type="checkbox"/> <b>Provider</b>		<input type="checkbox"/> <b>Group</b>	
<b>Name*</b>			
<b>Physical Address*</b>			
<b>City, State, Zip*</b>			
<b>Contact Name*</b>			
<b>Contact Phone</b>			
<b>Contact Email Address §</b>			
<b>MID*</b>	<b>TID*</b>		
<input type="checkbox"/> <b>Provider ID*</b>		<input type="checkbox"/> <b>TAX ID*</b>	

\* Required Information

§ All Approval Notifications will be sent to this address

#### Submit Original Payer Registration forms that require original signatures to:

Emdeon Business Services  
Attn: Enrollment  
1283 Murfreesboro Road  
Nashville, TN 37217-2421

For all other forms:

Fax: 615-843-2525

**To avoid rejections, please do not submit eligibility transactions before receiving Approval Notification from WebMD.**

# CAREPLUS HEALTH PLAN OF FL EDI Enrollment Form

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Provider Name: \_\_\_\_\_

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Contact Name: \_\_\_\_\_

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Tax ID: \_\_\_\_\_

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**WebMD Sales Contact Name:** \_\_\_\_\_

**Date of Activation:** \_\_\_\_\_

**\*\*\*\*\*All forms should be emailed or faxed to WebMD\*\*\*\*\***

**Fax: 615-843-2525**

**Email: [mir\\_request@webmd.net](mailto:mir_request@webmd.net)**

**11/20/03**