Agreement to Send Electronic

New York Rochester Preferred Care (SX089)

This agreement must be completed and approved by Emdeon prior to sending electronic claims through ENS.

Instructions for completing this form:

1. Complete one agreement for each Tax ID/group number.

2. Complete the following:
   Batch Claim Provider Set up Form
   - Section 1 – Complete the Reimbursement information
   - Section 3 – Complete the Facility/Provider information. The street address Cannot be a PO Box.
   - Section 5 – The Rochester Preferred Care provider number must be included. DO NOT include Provider numbers for any other payers.

   Emdeon information sheet
   - Complete the provider information.

   Preferred Care Electronic Claims Submission Program; Letter of Intent to Participate
   - Complete the group name and the date to begin sending claims.
   - The original signature of each provider and the provider number must be included.

3. After completing the agreement:
   - Mail the **<u>original</u>** agreement to:
     Electronic Network Systems
     ATTN: Enrollment Dept.
     1755 Telstar Drive, Suite 400
     Colorado Springs, CO 80920

Please call the ENS Enrollment Department at 719-277-7545, option 5 with any questions regarding this Agreement.

GATE0079

EMAIL to: batchenrollment@webmd.net
Or FAX : (615) 885-3713

BATCH CLAIMS PROVIDER SET UP FORM

CLAIMS TYPE: ☒ **Medical** ☐ **Hospital** ☐ **Dental** Revised 0305

1 REIMBURSEMENT INFORMATION (*Facility or Provider/Group*)

Pay to Name
Pay to Address
City: State Zip Code
Contact Phone
Fax E-mail Address
ID# for Claims Submission ☐TAX ID ☐SSN Site ID F042
Billing Account Type ☐ Vendor ☒ Provider/Group ☐ Facility ☐ Billing Service/Dealer

2 PRODUCT TYPE (*Product used to Submit Batch Claims to WebMD*) *Check only one box*

☐ WebMD Certified Vendor: TSO ID *F042* Communication Protocol *Secure FTP over the Internet*
Vendor/Submitter ID *841162764* Vendor Report Format *Print Readable*
Xpedite Customer Number (WebMD USE
☐Xpedite ONLY): *10-*
☐Other Product Name Customer #/User ID

3 FACILITY/PROVIDER INFORMATION

Facility/Group Name
Provider Name Title
Mailing Address
City State Zip Code
Street Address
City State Zip Code
Site ID F042 *(if necessary)* Tax ID
Provider Specialty Code Type of Practice Code SSN
UPIN License # State

4 INSTITUTIONAL (UB92) PAYER SELECTION LIST

☐ Commercial:
☐ Paper: Check here if you want WebMD to print & mail paper claims for you.
☐ Medicare Payer ID State Hospital Primary# _ Hospital Secondary# _
☐ Medicaid Payer ID State Hospital Primary# _
☐ Tricare Payer ID State Hospital Primary# _ Region _
☐ Blue Cross Payer ID State Hospital Primary# _
☐ Medicare HomeHealth State Hospital Primary# _ Hospital Secondary# _

5 PROFESSIONAL (HCFA 1500) PAYER SELECTION **WebMD Payer List:** http://www.webmdenvoy.com/pages/payers/lists.html

For payers that require additional enrollment, enter Payer ID(s) from WebMD Payer List(s). Indicate the state abbreviation and provider number(s) for each. If additional rows are required for Payer ID selection, complete additional Provider Setup forms.

☒ Commercial Payer ID SX089 Prov. ID Payer ID Prov. ID
☐ Paper: *Check here if you want WebMD to print & mail paper claims for you.*
☐ Government Payers/Blue Cross Blue Shield

Medicare Participating? ☐Yes ☐No *Will default to YES if not marked*

Payer ID State Individual # Group#
Payer ID State Individual # Group#
Payer ID State Individual # Group#
Payer ID State Individual # Group#
Payer ID State Individual # Group#

6 VENDOR/BILLING SERVICE/SOFTWARE INFORMATION

Vendor Name	Electronic Network Systems	Billing Service	
Contact	Bjana Santana	Contact	
Address	7899 Lexington Dr. Ste 203 CS, CO 80920	Address	
Fax	719-277-0254	Fax	
Phone	719-277-7545	Phone	
E-mail	enrollments@enshealth.com	E-mail	
Software Name	ANSI	Customer #	

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Send Setup Notification to: ☐**Do Not Send Setup Notification** ☒**Vendor** ☐**Billing Service/Dealer** ☐**Facility/Provider**
Send Payer Correspondence and Payer Approvals to: ☒**Vendor** ☐**Billing Service/Dealer** ☐**Facility/Provider**

For Payer Registration Forms go to: http://www.webmdenvoy.com/pages/payers/payenroll.html

NEW YORK ROCHESTER PREFERRED CARE

For Initial Enrollment with this payer:

- If you have NOT submitted claims electronically to this payer, the Payer requires Payer Registration forms. Please complete all fields on the following page(s) as well as the attached Payer Registration forms and return to Emdeon for processing.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies are accepted.
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site http://www.emdeon.com.

For Re-Enrollment (COS Change of Service) with this payer:

- If you have submitted claims electronically to this payer in the past, either directly or through another clearinghouse, and would like to submit through Emdeon, the Payer requires payer registration forms.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies are accepted.
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site http://www.emdeon.com

If you are already APPROVED by this payer to submit through Emdeon:

- If you have already received an approval from this payer to submit claims electronically through Emdeon, you must notify Emdeon so that we may process your approval in our enrollment systems. Please submit a **Client Provided Approval Form** to Enrollment for processing.
    - You may obtain the form from our enrollment web site http://www.Emdeon.com.or by calling our Fax on Demand service at 1-800-760-2804 (doc# 1450).
    - The Client Provided Approval form must be submitted to: payerregistration@Emdeon.com , or faxed to 615-885-3713.

Payer Registration Reminders:

- Please keep a copy of all forms for your records.
- Please verify that all pages in the agreement are included when mailing.
- Please ensure that all required fields are completed and legible.
- Please provide a physical address below in case we need to Fed-Ex your agreement back to you.
- Please remember to sign and date all documents. Your software vendor must be certified to send All-Payer claims to Emdeon. Please contact your vendor if you have questions regarding certification.
- To obtain forms or additional payer information, visit our website: http://www.Emdeon.com.

NEW YORK ROCHESTER PREFERRED CARE

Instructions for submitting Payer Registration Forms:

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

This Registration form is for a: ☐Provider ☐Group			
Name*			
Physical Address*			
City, State, Zip*			
Contact Name*			
Contact Phone			
Contact Fax			
Contact Email Address §	enrollments@enshealth.com		
☐**NPI ID***		☐**Group ID***	
		☐**Provider ID***	
☐**Tax ID*** ☐ **SSN**		**Site ID***	F042
Vendor Submitter ID*	841162764	**Division ID***	
Vendor Name*	Electronic Network Systems, Inc. (ENS)		
Additional Info			

* Required Information if applicable. § All Approval Notifications will be sent to this address

Submit Original Payer Registration forms that require original signatures to:

Emdeon Business Services
Attn: Enrollment Dept
Donelson Corporate Ctr Bldg 3
3055 Lebanon Pike Ste 2000
Nashville, TN 37214

For all other forms:

Fax: (615) 231-4843
Email: batchenrollment@Emdeon.com

To avoid claim rejection, please do not submit electronic claims before receiving Emdeon Approval Notification.

Preferred Care Electronic Claims Submission Program

Letter of Intent to Participate

I/We _____ express my/our intent to participate in Preferred Care's Electronic Claims submission Program.

I/We have read, understand, and agree to abide by the terms expressed within the Electronic Claims Submission Program document.

I/We agree to follow the established submission format and to provide Preferred Care with all information necessary to process claims, including adherence to mandatory fields and submission guidelines established by Preferred Care. I/We agree to obtain all necessary authorization access signatures, as expressed in this document, from my/our patients.

I/We agree to submit electronic media with an error percentage of less than 5 percent to become and remain eligible for the program.

I/We expect to begin submitting claims processing test data on _____

I/We expect to begin submitting data for claims processing and payment on _____

I/We understand that this letter is an application to participate in Preferred Care's Electronic claims Submission Program and does not constitute acceptance.

Any person who knowingly and with intent to defraud any insurance company or other person, files an application of insurance or statement of claim containing any materially false information, or conceals, for the purpose of misleading, information concurring any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5000.00 and the stated value of the claim for each such violation.

By:_____Date:_____
_Prov ID#_____

By:_____Date:_____
_ Prov ID#_____

By:_____Date:_____
_ Prov ID#_____

By:_____Date:_____
_ Prov ID#_

Please return this form to the Supplier Automation Coordinator, c/o Preferred Care, 259 Monroe Ave, Rochester, NY 14607.

For Group Practices: Each provider intending to submit electronically or one group representative must sign this letter of intent.

Sign-Up Information

Provider Name: _____

Address: _____

Access ID ENBS0007 _____

Transmission Protocol (Circle One)

A. XMODEM B. MODEM7 C. YMODEM

(D. KERMIT) E. TERM5 F. UUCP

_____

System Name

Modem Speed (Circle One)

A. 14.4 B. 9600 C. 19.2 (D. 28.8)

Operating System (Circle One)

A. Dos (B. Unix) C. Xenix

D. Macintosh E. Other: _____

Communication Software (Circle One)

A. ProComm(Plus) B. CrossTalk C. Windows Terminal

D. UUCP E. MacTerminal F. Other: (Kermit)

The software package I/We use at this office is:

Software: _____
Contact Person _____

Return to:
Preferred Care
Supplier Automation
259 Monroe Avenue
Rochester, New York 14607

The Supplier Automation Coordinator will assign a password for your office after processing this form.