Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway
P.O. Box 8190
Madison, WI 53708-8190
Phone: (608) 221-4711

Dear WPS Provider:

Reminders: Complete and return all 3 pages

Thank you for choosing the electronic method for submission of your healthcare claims. Wisconsin Physicians Service requires that all new electronic providers/groups sign, and have on file, a "Provider Agreement to Submit Electronic Media Claims" prior to submitting electronic claims. We request that you complete and return this agreement form, including this cover letter, to our office.

An organization that has several providers can execute a single Provider Agreement form on behalf of the group. Only one authorizing individual is needed to sign the agreement for the Clinic/Group. *(Note: A separate agreement is required for each Tax ID.)*

In addition to the agreement, the following information is needed (please print):

Clinic Tax ID:	**Clinic NPI Number(s):**
Physician/Clinic/Institution Name:	
Address:	
City/State/Zip:	**Billing Service/Clearinghouse (if applicable):** Lindsay Technical Consultants, Inc.
Contact Name:	**Phone Number:**
Contact e-mail address:	**Fax Number:**
Provider/clinic/institution physical location(s) address:	
NOTE: If you have multiple physical locations, please attach a list including the associated billing and NPI address for each	

Please indicate your EDI submission option:

☒ **Name of Billing Service/Clearinghouse (**if applicable**)**: Lindsay Technical Consultants, Inc.

☐ **Direct Filing via WPS Bulletin Board System or Internet Batch** (using vendor supplied EDI software program and transmitting from your site) **Name of Vendor if Billing direct (**if applicable**):** _____

- If this option is selected, please register as a submitter through the WPS Trade Partner System (WTPS) at **https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do.**
- If you have already registered as a submitter, please provide the submitter number assigned _____.
- If you need assistance with registration, please contact WPS Electronic Data Services at 800-782-2680, option 4.

☐ **PC-Ace software – Free claims submission software supplied by WPS**

Please indicate your method of transmission if sending Direct:

_____ **WPS-batch Internet claim submission** _____ **WPS Bulletin Board System**

**Please note*: A faxed, e-mailed faxed image or original will be accepted. Please mail, fax or e-mail your completed agreement to:

WPS Electronic Data Services
WPS Insurance Corporation
P.O. Box 8128
Madison, WI 53708-8128
Fax (608) 223-3824
E-Mail Address: **edi@wpsic.com**

Note: If you are a new provider/location or have recently changed your physical or billing address, it is important that WPS update our provider file before you submit your EDI Provider Agreement. Please contact WPS/EPIC Member Services at 1-800-765-4977 for in-state providers or 1-800-356-8051 for out-of-state providers. You can also fax your updated information to 608-221-6161.

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For Office Use Only

BL(s) _____ _____, _____ _____, _____ _____, _____ _____

Sub # _____ CH _____ Direct _____ CTY_____

EACV: _____ WC _____ G _____ M _____ C _____ S _____

ALS _____ App Dt _____

Orig Sub # _____ New Sub # _____ Memo _____ ERAU _____ Initials _____

EXHIBIT A

PROVIDER AGREEMENT TO SUBMIT ELECTRONIC MEDIA CLAIMS FOR REIMBURSEMENT BY WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION

It is hereby agreed between Wisconsin Physicians Service Insurance Corporation (hereinafter referred to as WPS), and the undersigned health care provider, (hereinafter referred to as "Provider"), that said Provider is appointed to submit claims via electronic media for reimbursement by WPS for services rendered to WPS health plan subscribers and dependents. This appointment is conditioned upon the Provider fully agreeing to and following all of the terms and conditions set forth in this Agreement, the Attachment A as applicable and clearing WPS internal provider review standards for acceptance and payment of EMC submitted claims.

TERMS AND CONDITIONS

1. In submitting Electronic Media Claims, Provider agrees to submit such claims edited and formatted according to the specifications indicated within the user's guide supplied by WPS. Provider understands the WPS EMC user's guide is proprietary and is authorized for use only by Provider and its employees working on its behalf to submit such electronic media claims. Any other use or distribution of the WPS EMC user's guide is strictly prohibited without the express written consent of WPS. WPS shall be the final authority in resolving any discrepancies in how electronic data shall be submitted.

2. Provider agrees that each and every claim submitted via electronic media, for all legal and other purposes, will be considered signed by the Provider or Provider's authorized representative.

3. Provider agrees to maintain a patient signature file. Provider understands WPS may validate through file audits, those claims submitted via electronic media which are included in any quality control or sampling method requested by WPS. Provider understands if no signed authorization is on file, an authorization must be obtained prior to claim submission.

4. Provider agrees that WPS or representatives of WPS, have the right to audit and confirm any source documents, including, but not limited to, medical records, claim forms, and Explanation of Benefits from Primary Carriers, that are relevant to claims submitted to WPS electronically. Any incorrect payments which are discovered as a result of such an audit will be appropriately adjusted.

5. Provider will ensure that each electronic media claim submitted can be readily associated with all source documents in an auditable fashion for no less than seventy-two (72) months following the date of payment by WPS. All medical records will be maintained according to the laws of the state in which the services are provided.

6. Provider agrees to establish and maintain procedures so that information concerning WPS subscribers and dependents or any information obtained from WPS shall not be used by Provider or Provider's agents, officers or employees except as provided by Federal or State Law including the Freedom of Information Act, Drug Abuse Office and Treatment Act (42 U.S.C. s290ee-3) and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (42 U.S.C. s290dd-3). Provider agrees not to disclose any information concerning a WPS subscriber to any person or organization other than WPS, without the express written permission of the WPS subscriber or his lawful representative.

7. The undersigned provider understands that the submission of an electronic media claim to WPS is a claim for WPS payment and that any misrepresentation or falsification of records relating to that claim is Subject to prosecution under federal criminal and civil law and the laws of the State of Wisconsin and, upon conviction, will result in fines and/or imprisonment.

8. This agreement may be terminated at any time by either party to this Agreement by giving five (5) days written notice of such termination to the other party.

9. Provider agrees that WPS may test any submission against validity and consistency edits as defined in the user's guide provided by WPS. Provider understands that WPS will accept all valid claims which meet such edit requirements and return such errant submissions for correction.

In the event that errors are identified on claims which pass these edits and have been accepted into the WPS adjudication system, WPS will work with the Provider to remedy such errors. However, data errors submitted by Provider will be identified to the Provider in writing by WPS and Provider will remedy such errors within five (5) working days or face possible suspension from the EMC program or termination of this Agreement.

10. WPS reserves the right to refuse for any reason to accept electronic media claims covered by this Agreement.

11. All required notices under this Agreement shall be sent by certified mail, postage prepaid, return receipt requested.

The signed agreement or any questions related to the agreement shall be mailed to:

Wisconsin Physicians Service
Electronic Data Service
PO Box 8128
1717 W. Broadway
Madison, WI 53708-8128

If such notice is sent to the Provider, it will be addressed to the individual named in the Provider's signature blank below, and sent to the mailing address shown below for the Provider.

12. This Agreement may not be modified or changed orally. All modifications must be made in writing signed by both parties.

13. The interpretation and legal effect of this Agreement shall be governed by the laws of the State of Wisconsin.

14. This Agreement shall be binding upon, and inure to the benefit of the successors, assigns and legal representatives of each of the parties hereto. However, it shall not be assigned by either party without the written consent of the other party.

15. It is agreed that the relationship of the parties hereto is that of independent contractors and this Agreement does not constitute either party as agent, partner or employee of the other party.

16. By executing this Agreement below, Provider agrees to all of the terms and conditions of the Agreement. Provider further agrees to begin to submit claims electronically only after Provider has received a written notice from WPS stating permission to do so has been granted.

_____	WISCONSIN PHYSICIANS SERVICE
Name of Provider	INSURANCE CORPORATION
_____	
Tax ID Number of Provider	
_____	
NPI Number of Provider	
_____	
_____	
Mailing Address	
By _____	By _____
Signature and Title of Provider or Authorized Officer	WPS Authorized Signature
_____	_____
Date	Date