

California - Sutter Connect Payer Agreement Instructions

Are you set up with the Payer?

This enrollment form is for submitters who have completed all necessary arrangements with this payer. Although payer requirements vary, please be sure to:

- Register your NPI with this Payer
- Contract with this Payer, if needed. You must have a valid Provider Identification Number (PIN).

In addition there may be other EDI payer requirements. For more specific information please contact the Payer's Provider Relations Department.

McKesson Requirements

Complete the Exhibit B & Carrier Agreement Tracking Form (CAT Form) and fax to the McKesson EDI Enrollment Department at: 800-633-4763. These forms are included in the next two pages.

- This form is used to update the provider/practice profile with the correct information so that approval can be obtained from the payer for electronic submission.
- This form can also be used if you are making changes to an existing setup for this payer, i.e. change to Provider PIN or NPI.
- Please ensure that any tracking information is included. This is used when contacting the payer for approvals.
- Failure to complete this form and submit to McKesson may delay the processing of this payer with the clearinghouse.
- The Exhibit B & CAT Form does not go to the payer, only to McKesson EDI Enrollment.

Payer Enrollment

- Some payers require original forms.
- If the payer accepts copies, be sure to include all pages of the agreement and verify that they are legible.
- Submit one agreement per Provider Group ID
- Incomplete or incorrect agreements may be denied or returned by the payer and may require the enrollment process be started from the beginning.
- Approvals can take 3 – 4 weeks.

Payer Approvals

- In some cases the payer will send the approval to the provider/practice instead of notifying the clearinghouse. If you receive payer approval please let us know by faxing a copy to EDI Enrollment at: 800-633-4763.
- DO NOT transmit claims to this payer until you have verified with the Enrollment Department that the clearinghouse has received and updated the approval in their system.

Guidelines for completing: Sutter Connect – All Plans

**When you have completed this agreement
please fax to the payer at:**

(916) 854-6722

| CLAIMS: | ENCOUNTERS: |
|-----------------------------------------|-----------------------------------------|
| Alta Bates MG – IP084 | Alta Bates MG – HM056 |
| Delta MG – IP100 | Delta MG – HM063 |
| Santa Rosa Network – IP090 | Santa Rosa Network – HM057 |
| SIP, SMG, SWMG – IP092 | SIP, SMG, SWMG – HM059 |
| Solano Regional Medical Group – IP099 | Solano Regional Medical Group – HM062 |
| Sutter Gould Medical Foundation – IP091 | Sutter Gould Medical Foundation – HM058 |

**EzConnect Electronic Encounter/ Claims Submission Provider Application Section 1:
Provider Information**

| Section | Instructions |
|-------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------|
| Provider Name, Service Address, City, State, Zip, Mailing Address, City, State, Zip, Contact Name, Telephone/ FAX Numbers, Email Address: | Complete as indicated. |
| 9 Digit Federal Tax ID Number: | The federal tax ID of the practice/ provider. |
| State License Number (attach list if necessary): | The state license number of each provider in the practice. |

Section 2: Data Specifications Information

| Section | Instructions |
|-------------------|--------------------------------------------------------------------------------------------------------------------------|
| Line of Business: | Complete with the “estimated monthly volume” of the plan that your practice wishes to transmit claims or encounters for. |

Once the Sutter Connect form(s) has been completed and faxed to the payer, please complete the **McKesson Ex. B & CAT Form** and fax to:

| |
|--------------------------------|
| McKesson EDI Enrollment |
|--------------------------------|

800-633-4763

FAX TO 1-800-633-4763

Each provider in the practice planning to submit health care transactions electronically must be included in this enrollment form. If a provider has more than one office, please complete a separate form for each office.

PLEASE CHECK ONE OF THE BELOW CHOICES

- Add on Provider (Adding Provider to existing McKesson Account)*
- Add on Payer (Adding Payer to a Provider with an existing McKesson account)**
- Update or Change to a Provider’s PIN or Group Number for requested payers.**

*Adding a provider to an account may result in a pricing increase depending on the pricing plan you are currently on. If you are not sure what pricing plan you are on, please contact your Value Added Reseller or the EDI Enrollment Department at 1-800-689-4550

** If adding or changing information regarding an Insurance Carrier/Payer for an existing provider you must also complete the Carrier Agreement Tracking Form (CAT Form) which is page 2 of this document.

Client ID: _____ Practice Tax-ID: _____

Practice Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ VAR # _____

Telephone: _____ Facsimile: _____

Billing service name: _____ Billing Service Tax
 ID: _____ (If applicable) (If
 applicable)

| <i>First Name</i> | <i>Last Name</i> | <i>Credential</i> | <i>Specialty</i> | <i>Individual NPI</i> | <i>Group NPI</i> |
|-------------------|------------------|-------------------|------------------|-----------------------|------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | |
|-------------------------|--|
| Practice Name: | |
| Practice Tax ID: | |

Please include this form with the Exhibit B. Complete this form for each provider in the practice after all agreements have been forwarded to the respective carriers. You may wish to retain a copy of this form for your records.

In the grid below, please enter **ALL** of the requested information for each carrier/payer to enroll. **This is critical information that is required to complete your enrollment process. The clearinghouse cannot contact payers to confirm your approval for electronic transmission without first knowing the date agreements were mailed to them.**

***Please indicate the appropriate Payer ID Number below each payer as indicated in the payer directory. The Phoenix Payer Directory can be found online at http://www.lytec.com/download/Phoenix_Payer_List.pdf for Lytec users or at http://www.medisoft.com/download/Phoenix_Payer_List.pdf for Medisoft users**

| Payer | Provider #1 | Provider #2 | Provider #3 |
|--------------------|-------------|-------------|-------------|
| | Name: | Name: | Name: |
| | Ind NPI: | Ind NPI: | Ind NPI: |
| | Group NPI: | Group NPI: | Group NPI: |
| Medicare | Ind # | Ind # | Ind # |
| | Grp # | Grp # | Grp # |
| Medicaid | Ind # | Ind # | Ind # |
| Payer ID | Grp # | Grp # | Grp # |
| BCBS | Ind # | Ind # | Ind # |
| Payer ID | Grp # | Grp # | Grp # |
| TriCare | Ind # | Ind # | Ind # |
| Payer ID | Grp # | Grp # | Grp # |
| RR Medicare | Ind # | Ind # | Ind # |
| Payer ID | Grp # | Grp # | Grp # |
| Other | Ind # | Ind # | Ind # |
| Payer ID | Grp # | Grp # | Grp # |
| Other | Ind # | Ind # | Ind # |
| Payer ID | Grp # | Grp # | Grp # |

Please note the date on which you sent each carrier agreement to the carrier and the service used to send it (i.e., UPS, FedEx, Airborne Express, etc.) as well as a package tracking number, if applicable.

| Carrier/Payer Name | Date Mailed | Service Used | Tracking Number |
|--------------------|-------------|--------------|-----------------|
| | | | |
| | | | |
| | | | |



**ezConnect Electronic Encounter/Claims Submission
Provider Application**

| Section 1: Provider Information | | | | |
|--------------------------------------------------------------------------------------------------------------|------------------------------------------------------|--------------------------------------------------------|---------------------------------------------------|--------|
| Provider Name | | Provider NPI: | Group NPI: | |
| Service Address | | Mailing Address | | |
| City, State, Zip | | City, State, Zip | | |
| Contact Name | Telephone/FAX Numbers | | Email Address | |
| 9 Digit Federal Tax ID Number | | State License Number <i>(attach list if necessary)</i> | | |
| Section 2: Data Specifications Information | | | | |
| Which data standard do you plan to use to submit encounters/claims? | | | | |
| NSF 2.0 _____ UB92 4.0/5.0 _____ ANSI 837 _____ Version # _____ Unknown _____ | | | | |
| <i>If you plan to use NSF 2.0, please provide your NSF 2.0 Submitter ID: _____</i> | | | | |
| Line of Business | Professional (HCFA 1500) Estimated Monthly Volume | | Institutional (UB 92) Estimated Monthly Volume | |
| Alta Bates | | | | |
| Santa Rosa | | | | |
| Sutter Delta Medical Group | | | | |
| Sutter East Bay Medical Foundation | | | | |
| Sutter Gould | | | | |
| Sutter Independent Physicians | | | | |
| Sutter Medical Group | | | | |
| Sutter Regional Medical Foundation | | | | |
| Sutter Select | | | | |
| Sutter West Medical Group | | | | |
| Yolo Health Alliance | | | | |
| Medium used for electronic claims submission: <i>(please select one)</i> | | | | |
| Internet FTP | CD ROM | Diskette | DAT Tape | Other: |
| Section 3: Submitter Information | | | | |
| Please provide the following <i>(if applicable)</i> : | | | | |
| Practice Management Company Name | | Billing Service Name | | |
| Clearinghouse Name | | | | |
| <i>If none, may we forward this information to a clearinghouse?</i> _____ Yes _____ No _____ Signature _____ | | | | |
| Contact Name/Number | | Other (please explain) | | |
| Your Company Name <i>(if different than Section 1)</i> : | | | | |
| Your Address: | | | | |
| City, State, Zip Code (9 digit) | | | | |
| Contact Person: | Telephone/FAX Numbers | | Email Address | |

PLEASE RETURN COMPLETED ORIGINAL TO:

Sutter Connect, IT/EDI Dept.
P.O. Box 254707
Sacramento, CA. 95865-4707
Fax (916) 854-6722

For additional information or for assistance in completing the application, call 1-800-611-5191