PacifiCare®

EMCIMSCLAIM-195

COLORADO REGION

Trading Partner Request

Date Requested_____

Please fill out **completely**, Trading Partner requests will not be approved unless information is complete.

USER ID IMSCLAIM

PROVIDER NAME	CONTACT NAME	CONTACT PHONE NUMBER	CONTACT FAX NUMBER
Proxymed, Inc.	Enrollment Dept	(800) 792-5256 X 812	(770) 885-4559

BILLING ADDRESS	CITY	STATE	ZIP
1854 Shackleford Ct Ste 200	Norcross	GA	30093

PRACTICE MANAGEMENT SYSTEM	BUSINESS EMAIL ADDRESS	APPROXIMATE CLAIM VOLUME
	Provider.enrollment@proxymed.com	

Desired implementation date:_____

PLEASE NOTE: Providers need to provide test data to the Clearinghouse prior to the approved implementation date.

Will the provider send payable claims?	Yes	No
Will the provider send encounters?	Yes	No
Will the provider send any hospital claims?	Yes	No
Will the provider send any professional claims?	Yes	No
Is the provider able to send ALL required information?	Yes	No
Is the provider able to send the PacifiCare Tax ID and suffix(s)?	Yes	No

Provider Name	Specialty*	Tax ID	PacifiCare of Colorado Suffix(s)

- **Specialty types that require testing are: Anesthesiology and Hospital Facility Claims.**