

Payer Agreement Instructions for Delaware Blue Shield - BS042

Important Notes

The provider **must** be enrolled with the payer and have a valid Provider Identification Number (PIN) before completing the agreement to submit electronic claims. Please wait until the PIN has been assigned **before** completing these forms requesting submission of electronic claims. Please do not list the PIN as "pending".

To obtain a PIN for a specific payer, **the provider or Billing Service** must contact the payer's Provider Relations Department. McKesson **cannot** make this request for the provider.

- If making copies of the agreement, make sure it is legible.
- Submit one agreement for each Group ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 4- 6 weeks. If you receive an approval letter from the payer, contact us via phone or fax a copy to us. DO NOT transmit your claims until you receive an approval letter from McKesson or your claims will reject.

Guidelines for completing: Delaware Blue Shield - Payer ID BS042

Electronic Data Exchange Enrollment

Field	Instructions
<i>Provider Name or Group, Address (street, city, state and zip code), Contact Person, Telephone (include area code):</i>	Complete as indicated.
<i>Provider Number:</i>	Number assigned to provider or group practice by Delaware Blue Shield.
<i>Signature of Health Care Professional or Authorized Representative, Title, Type or Print Name, Date:</i>	This agreement must be signed by the provider or an authorized representative.

Return the Agreement to the Payer:

Fax

(302) 421-3265

Mailing address for USPS

Blue Cross Blue Shield of Delaware

Attention: Electronic Claims

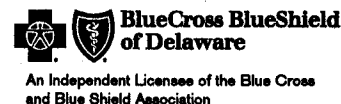
P. O. Box 1991

Wilmington, DE 19899



Blue Cross Blue Shield of Delaware • P.O. Box 1991 • Wilmington, DE 19899-1991

Phone: 302 421-8428
Fax: 302 421-8485
E-mail: emc@bcbsde.com
Web Site: www.bcbsde.com



Electronic Data Exchange Enrollment

Provider Name or Group Provider Number

Address (street, city, state and zip code)

Contact Person Telephone (include area code)

Adding to existing Submitter? Yes No. If Yes, Submitter Number:

Name of (check one): Software Vendor Billing Service

Address (street, city, state and zip code)

Contact Person Telephone (include area code)

If you are unable to answer any of the following questions, please contact your hardware/software vendor.

CLAIMS SUBMISSION

Modem Protocol (asynchronous only)

X modem Y modem Z Modem ASCII

Transmission Format

National Standard (NSF) Version:

OTHER SERVICES AVAILABLE (Check those desired.)

Claims Status Eligibility and Benefits
Electronic Remittance Advice

In accordance with specifications set forth by Blue Cross Blue Shield of Delaware (The Corporation) for submission of automated claims, I / we agree that:

The Provider agrees to submit claims in accordance with the Participating Contract and in the format specified by The Corporation.

The Corporation agrees to accept and process claims submitted in accordance with this contract. Such processing and payment will be according to the terms of the Participating Provider Contract.

The Provider will ensure that every claim submitted can be readily associated and identified with the patient's medical and business office records. All medical records and source documents will be retained for a period of six (6) years after the month the bill was submitted. These records may be retained on microfilm.

The Provider agrees that the Corporation or its designee will have reasonable access to all documents pertaining to claims submitted via electronic media for the purpose of auditing and confirming the claims information submitted. Such access will be permitted to documents in the possession of the Provider, as well as the Provider's billing agent(s).

The Provider agrees that any overpayments which are discovered and brought to its attention will be refunded within thirty (30) days of the date of notification.

The Provider will research and correct any and all billing discrepancies caused by submission of automated claims.

The Provider /Corporation will maintain the confidentiality of passwords, preventing unauthorized users from committing data security violations with my log-on identification.

Signature of Health Care Professional or Authorized Representative

Title

Type or Print Name

Date

Please mail the signed original to: Blue Cross Blue Shield of DE, Attn: Electronic Claims (4-2-04), P.O. Box 1991, Wilmington, DE 19899.

