

## **Payer Agreement Instructions for Geisinger Health Plan Payer ID75273**

### **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: Geisinger Health Plan – Payer ID 75273**

**EDI Provider Enrollment Application**

Field	Instructions
Section 1: Provider Information	Enter Provider information as requested
Section 2-3: Requesting ASCX12 HIPAA Transactions & Clearinghouse Information	Pre-Filled by MedAvant
Section 4: Provider/Facility Enrollment	List Providers submitting CMS1500 claims under tax ID listed in section 1. Sign and date Enrollment Application

Fax or return the Agreement to the Payer

**Mailing Address**

PNM Operations/EDI Enrollment 20-30  
100 N. Academy Avenue  
Danville, PA 17821-3020

**Fax**

(570) 271-5297

**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: \_\_\_\_\_  
ID: \_\_\_\_\_

**Billing Service Tax**

(If applicable)  
applicable)

(If

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

<b>Practice Name:</b>	
<b>Practice Tax ID:</b>	

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](http://www.lytec.com/download/Phoenix_Payer_List.pdf) for Lytec users or at [http://www.medisoft.com/download/Phoenix\\_Payer\\_List.pdf](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:
<b>Medicare</b>	Ind #	Ind #	Ind #
	Grp #	Grp #	Grp #
<b>Medicaid</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>BCBS</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>TriCare</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>RR Medicare</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>Other</b>	Ind #	Ind #	Ind #
Payer ID	Grp #	Grp #	Grp #
<b>Other</b>	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



**Electronic Data Interchange (EDI)  
Provider Enrollment Application**

**SECTION I: Provider Information:**

Practice/ Facility Name:	
Primary Physical Address:	Remittance Address:
County:	
Contact Person:	
Practice/Facility EDI Contact Person e-mail address: <b>(required for testing):</b>	
Practice/Facility Telephone #: ( )	
Practice/Facility Tax ID#:	
Type of Practice (indicate with an X):      Group: <input type="checkbox"/> Solo: <input type="checkbox"/> N/A: <input type="checkbox"/>	

**SECTION II: Requesting Application for the following  
ASC X12 HIPAA transactions:  
(place an “ X” in each applicable box)**

<b>837 I</b> ( Claim: Institutional) <input type="checkbox"/>	<b>835</b> (Claim Payment/Advice) <input type="checkbox"/>
<b>837 P</b> ( Claim: Professional ) <input type="checkbox"/>	<b>278</b> (Services Review-Request for Review and Response) <input type="checkbox"/> (BATCH PROCESS ONLY)
<b>270/271</b> (Eligibility/Benefit Inquiry and Response) <input type="checkbox"/> (BATCH PROCESS ONLY)	<b>276/277</b> (Claim Status Request and Response) <input type="checkbox"/> (BATCH PROCESS ONLY)

**SECTION III: EDI Software Vendor/Billing Company/EDI Clearinghouse/Practice Management System Information**

Name of EDI Software Vendor (if applicable):	Telephone #: ( )
Name of Billing Company (if applicable):	Telephone #: ( )
Name of EDI Clearinghouse if other than WebMD (if applicable):	
Name of Practice Management System (if applicable):	Telephone #: ( )
Provider EDI Contact Person:	Telephone #: ( )



**SECTION IV: Provider/Facility Enrollment**

(Within your organization or practice, please list each entity or provider permitted to submit claims under the Tax ID# as listed in Section I. If more than 6 entries are made, please make a copy of this form to complete the remaining entries.)

<b>Providers submitting UB92 claim forms:</b>	<b>Providers submitting CMS1500 claim forms:</b>
<u>Provider/Facility Name:</u>	<u>Provider Name &amp; Credentials</u> (if applicable):
<u>Provider/Facility Name:</u>	<u>Provider Name &amp; Credentials</u> (if applicable):
<u>Provider/Facility Name:</u>	<u>Provider Name &amp; Credentials</u> (if applicable):
<u>Provider/Facility Name:</u>	<u>Provider Name &amp; Credentials</u> (if applicable):
<u>Provider/Facility Name:</u>	<u>Provider Name &amp; Credentials</u> (if applicable):
<u>Provider/Facility Name:</u>	<u>Provider Name &amp; Credentials</u> (if applicable):

**Geisinger Health Plan/Geisinger Indemnity Insurance Company**

Attestation: Geisinger Health Plan (EDI) Provider Enrollment Application

I hereby apply to Geisinger Health Plan for the purpose of electronic exchange of data including, but not limited to, the minimum necessary protected health information (as defined under the Health Insurance Portability Accountability Act of 1996) between Geisinger Health Plan and myself, or my authorized agent related to electronic data exchange transactions.

Upon acceptance [approval] by Geisinger Health Plan, the information on this application shall be [activated] and the parties hereunder may begin the electronic exchange of such data. I, or my authorized agent, agree to notify Geisinger Health Plan within five (5) business days of learning of any change to the information contained within this application. Either Geisinger Health Plan or I may terminate the electronic exchange of data at any time [upon prior notification to the non-terminating party].

The information contained within this application is true, correct and complete in all respects to the best of my knowledge and belief. I understand that the misrepresentation of any material fact by me on this application could constitute grounds for termination of the transmission, receipt or otherwise access of electronic exchange of data between the parties.

\_\_\_\_\_  
Signature of Provider/Facility [Applicant]

\_\_\_\_\_  
Date