

Payer Agreement Instructions for HIP of greater New York - 55247

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. Per-Se **cannot** make this request for the provider.

- If making copies include *all* pages of this agreement and be sure they are all legible.
- Submit one agreement for each Provider or Group ID.
- Incomplete or incorrect agreements will be returned delaying enrollment and approval.
- Approval will take 3- 4 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 Per-Se or your claims will reject.

Guidelines for completing: HIP – Payer ID 55247

****FAX THE HIP PROFILE FORM TO BOTH HIP AND TO PER-SE'S EDI ENROLLMENT DEPARTMENT.**

Return the Profile Form to the Payer via fax:

HIP Provider E-Commerce fax

(646) 447-3185

Return the Profile Form to the Per-Se:

Per-Se's EDI Enrollment fax

(800) 633-4763

HIP Health Plan of New York - Electronic Claims Submission Information Requirements

Section A: To be completed by PC, Physician or Billing Manager. Upon completion, please fax to HIP Provider E-Commerce (646-447-3185). Please do not submit claims electronically to HIP until you are advised by HIP-IS to proceed.

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|--------------------|--|
| Pay to Name: | |
| Tax ID: | |
| UPIN Number: | |
| Billing Address | |
| Servicing Address: | |
| Telephone Number: | |
| Fax Number: | |

Affiliated Physician Roster: (List Physician's Last Name, First Name, NY State Physician License Number). Note: If extra space is required, please attach a separate sheet of paper to this form.

| Last Name | First Name | NY SLN |
|-----------|------------|--------|
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Physician Office/Contact Name: _____

Email Address: _____

Practice Management Software: _____

Note: HIP will process claims according to the servicing locations fee schedule based upon the contractual agreement between HIP and the Provider. If you would like to discuss which option is best for your Practice Management System, please call HIP at 1-800-447-8386.

Please read and sign the following acknowledgement:

I agree that any claims submitted to HIP EDI format shall comply with security and privacy requirements applicable to individually identifiable financial and health information as set forth in (i) the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, as amended from time to time ("HIPAA"); and (ii) Title 11 NYCRR Section 420, as may amended from time to time ("New York State Insurance Regulation 169").

Acknowledge and Agreed :