

## Payer Agreement Instructions for Iowa Blue Shield - BS030

### 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. NDCHealth **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 Tax 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 ProxyMed or your claims will reject.

### Guidelines for completing: Iowa Blue Shield- Payer ID BS030

#### Electronic Registration Form

Field	Instructions
<i>EMC Software Vendor</i>	Entry fields for name and address of your Practice Management Software (PMS) company
<i>Provider Name</i>	Name of practice/provider
<i>Address, City, State, Zip</i>	Physical address of practice/provider
<i>Phone</i>	Of the practice/provider
<i>Line of Business</i>	Pre-checked
<i>Group Provider Number(s)</i>	Enter group Blue Shield numbers, if applicable.
<i>Rendering Provider Name and Number(s)</i>	Name and Blue Shield rendering number of each provider in this practice. <i>Iowa Blue Shield provider numbers consist of 5 digits.</i>
<i>Authorized Signature/ Date (REQUIRED)</i>	This agreement must be signed with the <u>original</u> signature of the provider or authorized agent. Stamped signatures will not be accepted. Include date signed.

### Signature and Audit Agreement

Field	Instructions
<i>Signed</i>	This agreement must be signed with the <u>original</u> signature of the provider or authorized agent. Stamped signatures will not be accepted.
<i>Provider Name</i>	Name of practice/provider
<i>Address, City, State, Zip</i>	Physical address of practice/provider
<i>Group Provider Number</i>	Enter group Blue Shield provider number, if applicable.
<i>Rendering Provider Number</i>	Provider's rendering Blue Shield number. <i>Iowa Blue Shield provider numbers consist of 5 digits.</i>
<i>Date</i>	Date signed

### Provider Authorization for Electronic Transactions through Third Party

Field	Instructions
<i>Administrator/Officer</i>	Name of administrator/officer for the practice
<i>Title</i>	Title of person named above
<i>Provider Office Name</i>	Name of practice/provider
<i>Provider Submitter # (if applicable)</i>	Practice/provider's Blue Shield submitter number, if currently submitting electronic claims to this payer.
<i>List all provider numbers and names.</i>	List provider names with Blue Shield rendering numbers. Attach a list if more space is needed
<i>Provider Office Name</i>	Name of practice/provider
<i>Provider address, city, state, zip</i>	Physical address of the practice/provider
<i>Phone</i>	Of practice/provider
<i>Fax</i>	Of practice/provider
<i>Signature of Administrator in Provider Office/Date</i>	<u>Original</u> signature of administrator and date signed.

Please mail completed Agreement to the following address:

Electronic Commerce Solutions  
636 Grand Ave.  
Mail Station 142  
Des Moines, IA 50309



*EC Solutions*

The following document is the Electronic Transaction Registration Form. This form may be used for the purposes listed below. **The registration process takes approximately 1 week to complete and you may be requested to complete additional agreements depending on your request(s).**

**\*\*\*ALSO PLEASE NOTE THAT YOU MUST HAVE A VALID IOWA OR SOUTH DAKOTA WELLMARK BLUE CROSS AND BLUE SHIELD PROVIDER NUMBER TO REGISTER.**

- ◆ Please complete and sign the registration form. The signature (located at the bottom of the form) must be from a provider or an office administrator authorized to sign on behalf of the doctors or facility.
- ◆ **SUBMITTER:** refers to the party that will be sending the claims electronically to INet. This may be a billing service, clearinghouse, or provider.
- ◆ **PROVIDER:** refers to the facility or physician providing the healthcare services. Please use the clinic name if different from the doctor's name.
- ◆ **VENDOR:** refers to the company that supports your electronic claims submission software. If you design your own software, you are the vendor.

You can use the registration form to request any of the following:

◆ **Interchange Network (INet) Access**

If you are not currently submitting electronic claims through INet and wish to do so, you will need to complete the Electronic Transaction Registration Form. You will also need to complete the Signature and Audit Agreement. You will need one Signature and Audit Agreement per provider number that you want to set up for electronic claims submission. The Office Manager or the individual who is responsible for the electronic claims can sign the Signature and Audit Agreement.

◆ **Adding provider numbers to your existing Submitter ID**

If you are a current submitter and need to register a new provider, list the provider numbers to be added on the Electronic Transaction Registration Form. Please be sure to provide your group provider number if applicable. You are also required to complete one Signature and Audit Agreement (for Wellmark Blue Cross and Blue Shield) per provider number that you are setting up electronically. NOTE: Wellmark Blue Cross and Blue Shield of Iowa provider numbers are 5 digits and Wellmark Blue Cross and Blue Shield of South Dakota provider numbers are 7 digits.

After you return the completed forms to EDS EC Solutions, we will begin the registration process. The completed registration forms can be faxed to the EC Registration Department at **1-515-235-4187**. Your submitter ID number, INet ID and INet Password Security letter will be mailed to you at the address that you listed on the registration form under "Submitter Address." This process can take up to 1 week for new submitters. Please be sure to check the boxes for the lines of business (LOB) for which you will be submitting electronic claims. Once your provider numbers have been set up for electronic transactions you will receive a confirmation call from the EC Registration Department to let you know the provider numbers are set up and ready to submit electronically.

Questions? Call Locally 515-248-5246 or Toll Free 800-407-0267

**Electronic Registration Form**

Electronic Commerce Solutions

Registration for: Wellmark Blue Cross and Blue Shield, Blue Dental,  
DME (Wellmark Only), First Administrators, INC.  
Commercial, & Iowa Medicaid

Electronic Commerce Solutions Fax 515-235-4187

636 Grand Avenue

Station 142

Des Moines, IA 50309

Local 515-248-5246 or Toll Free 1-800-407-0267

**\*\*YOU MUST HAVE AN IOWA OR SOUTH DAKOTA WELLMARK BLUE CROSS AND BLUE SHIELD PROVIDER ID TO REGISTER\*\***

Submitter Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Title: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

Submitter Address 1: \_\_\_\_\_

Submitter Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

County: \_\_\_\_\_ Email Address: \_\_\_\_\_

Do you already have a submitter ID? (this is separate from your provider number) YES  NO

If yes, what is your Submitter ID? \_\_\_\_\_

**As a result of HIPAA regulations, we need to know if you provide clearinghouse services for electronic transactions.**

YES  NO

Do you want Electronic Remittance Advice (ERA)? YES  NO

To what submitter number do you want it delivered? \_\_\_\_\_

**EMC Software Vendor**

Vendor Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

**Provider Information**

Provider Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_

**Lines of Business:** Blue Shield (1500)  Blue Cross (UB92)  First Administrators Inc.  Blue Dental   
DME (Wellmark Only)  Commercial  Iowa Medicaid

**Provider Numbers:**

Group Provider Number(s) \_\_\_\_\_

Rendering Provider Name & Number(s): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If additional space for provider numbers and names is needed, please attach a list to this agreement.

If you would like to purchase Procomm Plus Software, please select the version needed.

Send Procomm Plus Software (includes automated dial-in scripts, support and installation instructions)

**Windows 95/98/ME/NT**  **\$138.50** (\$125.00 + \$7.50 sales tax + \$6.00 shipping/handling)

**Windows 2000**  **\$212.70** (\$195.00 + \$11.70 sales tax + \$6.00 shipping/handling)

**Not supported for Windows XP**

◆ Please include a check with your order. **NOTE:** If you are tax exempt please include a copy of your tax-exempt certificate.

Authorized Signature /Date (**REQUIRED**) \_\_\_\_\_

## SIGNATURE AND AUDIT AGREEMENT

WE (I) hereby authorize Wellmark Blue Cross and Blue Shield, acting on their own behalf or as fiscal agents for the administration of Title XVIII in Iowa or as agents of Blue Dental Plan and Pharmacy Service Corporation access to patients' files to:

- 1) Verify that valid patient authorizations are received and maintained for claims submitted from the office, when applicable.
- 2) Verify the validity and accuracy of the claims submitted.

In submitting machine readable claims, WE (I) understand that WE ARE (I AM) certifying that the required patient signatures, or, where applicable, appropriate signatures on behalf of the patient, and required physician certifications and re-certifications (PSRO certifications where applicable) are on file and that anyone who misrepresents or falsifies essential claims information, may, upon conviction be subject to fine and imprisonment under Federal law.

In the event that payment information is returned in machine-readable form, WE (I) understand that this information will cover all claims paid to this provider number whether they were submitted on paper or in machine readable form.

- Patient Authorizations (signatures) are not required for non-patients.
- ***Please photocopy this page for each provider number you need to register.***

Signed: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Group Provider Number: \_\_\_\_\_

Rendering Provider Number: \_\_\_\_\_

Date: \_\_\_\_\_



EC Solutions

EDS EC Solutions
636 Grand Avenue
Mail Station 142
Des Moines, IA 50309
Phone: 1-800-407-0267
Fax: 515-235-4187

Provider Authorization for Electronic Transactions
Via Third Party

I, \_\_\_\_\_, \_\_\_\_\_
(Administrator/Officer) (Title)

representing \_\_\_\_\_ submitter number \_\_\_\_\_
(Provider Office Name) (Provider Submitter # if Applicable)

authorize \_\_\_\_\_
(Clearing House/Billing Service)

submitter number \_\_\_\_\_ to submit my electronic claims to the EDS INet
(Clearing House/Billing Service Submitter #)

for the following provider numbers and names: \_\_\_\_\_
\_\_\_\_\_

If additional space for provider numbers and names is needed, please attach a list to this agreement.

Provider Office Name: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City, State and Zip Code: \_\_\_\_\_

Phone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

\_\_\_\_\_  
(Signature of Administrator in Provider Office) (Signed Date)

Note: This box is only applicable if you currently receive Electronic Remittance Advices (ERA) or would like to receive ERA's in the future.
I would like my ERA to go to my office.
The submitter number for my office is: \_\_\_\_\_
OR
I would like my ERA to go to my Clearing House/Billing Service.
Their submitter number is: \_\_\_\_\_