

## **Minnesota Blue Shield – Payer ID BS085 Payer Agreement Instructions**

### **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: Minnesota Blue Shield**

When you have completed this agreement please fax to the payer at:

**Fax:**

**(651) 662-7290**

**Trading Partner Registration Form**

Section	Instructions
Business Information:	Please be sure to enter information as requested.
Contact Information:	Please list primary & Secondary Contacts
Requesting PC-ACE Connect Software:	NA
Connectivity Method:	Pre-filled by MedAvant
Claim Types/Payers:	Pre-filled by MedAvant

Once the Blue Shield form(s) has been completed and faxed to the payer, please complete the **McKesson Ex. B & CAT Form** and fax to:

**McKesson EDI Enrollment**

800-633-4763

**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: \_\_\_\_\_ Billing Service Tax  
ID: \_\_\_\_\_ (If applicable) (If  
applicable)

<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



**Trading Partner Registration Form**

For accurate completion of this form, please see registration instructions found at [www.clearconnect.com](http://www.clearconnect.com).

For Registration **UPDATES ONLY** ★ (check all that apply)

<input type="checkbox"/> Business Name	<input type="checkbox"/> Connection Method (Direct/Indirect)	<input type="checkbox"/> Connectivity Type
<input type="checkbox"/> Business Address	<input type="checkbox"/> Contracting Provider ID	<input type="checkbox"/> Payer Change
<input type="checkbox"/> Tax ID	<input type="checkbox"/> Clearinghouse or Billing Service	<input type="checkbox"/> Other

Business Information		
<b>Type of Business:</b> (choose one)  <input type="checkbox"/> Provider <input type="checkbox"/> Clearinghouse <input type="checkbox"/> Billing Service <input type="checkbox"/> Software Vendor <input type="checkbox"/> Central Billing Office <input type="checkbox"/> Service Bureau	<b>Physical Address:</b>  Business Name _____  Street (P.O. Boxes are not accepted) _____  City, State, ZIP Code _____  Phone _____ Fax _____	<b>Trading Partner ID (if assigned):</b> ★ ID required if making UPDATES  <b>National Provider ID (NPI):</b> Please attach separate sheet for multiple NPIs  <b>Business Federal Tax ID:</b>

Contact Information		
Primary Contact	Secondary Contact	Connectivity Contact
Name _____	Name _____	Name _____
Phone _____ Fax _____	Phone _____ Fax _____	Phone _____ Fax _____
E-mail _____	E-mail _____	E-mail _____

**Requesting PC-ACE Connect Software (Note: Dial-Up is the only Connection Type available)**

**Connectivity Method** (choose either Indirect or Direct)

**Indirect** - Connecting through a Clearinghouse (CH), Central Billing Office (CBO), Billing Service (BS), or Service Bureau (SB)

\_\_\_\_\_ Name of CH, CBO, BS, SB \_\_\_\_\_ Phone \_\_\_\_\_

**Direct** - Connecting directly to ClearConnect (**A SIGNED AGREEMENT IS REQUIRED, found at [www.clearconnect.com](http://www.clearconnect.com)**)

**Direct Connection Type\*** (Select one type - Please see 837 Registration Instructions for details on the connection type options)

<input type="checkbox"/> Internet: VPN to Client	<input type="checkbox"/> Internet: VPN to VPN	<input type="checkbox"/> Internet: SSH (Secure Copy)	<input type="checkbox"/> Dial-Up (Required for PC-ACE)
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\* Additional Forms may be required when registering. Please see Registration Instructions for forms.

**Claim Types/Payers** (For each Claim Type you select, please check all Payer(s) that apply, and list Contracting IDs where required)

**Professional Claim - 837 P (version 004010X098A1)**

<input type="checkbox"/> Blue Shield MN* list Contracting Provider ID(s): _____	<input type="checkbox"/> MN Medicare Part B list Contracting/Group #(s): _____	<input type="checkbox"/> America's PPO	<input type="checkbox"/> Health Partners	<input type="checkbox"/> Preferred One
		<input type="checkbox"/> DHS/MN Medicaid	<input type="checkbox"/> Metropolitan Health Plan	<input type="checkbox"/> Prime West
		<input type="checkbox"/> Group Health Co-op	<input type="checkbox"/> Other Commercial Payers	<input type="checkbox"/> Ucare

\* If you have additional Contracting Provider IDs please attach a separate page

**Institutional Claim - 837 I (version 004010X096A1)**

<input type="checkbox"/> Blue Cross MN* list Contracting Provider ID(s): _____	<input type="checkbox"/> MN Medicare Part A list Contracting/Group #(s): _____	<input type="checkbox"/> America's PPO	<input type="checkbox"/> Health Partners	<input type="checkbox"/> Preferred One
		<input type="checkbox"/> DHS/MN Medicaid	<input type="checkbox"/> Metropolitan Health Plan	<input type="checkbox"/> Prime West
		<input type="checkbox"/> Group Health Co-op	<input type="checkbox"/> Other Commercial Payers	<input type="checkbox"/> Ucare

\* If you have additional Contracting Provider IDs please attach a separate page

**Dental Claim - 837 D (version 004010X097A1)** DECARE International (Delta Dental of MN) is the only dental payer available.

Send completed Registration Form via Fax: 651-662-7290 or E-mail: [register@clearconnect.com](mailto:register@clearconnect.com), Attention: ClearConnect Registration

**For Questions call 1-866-251-6742**