

## **Payer Agreement Instructions for New York Empire Blue Shield - BS033**

### **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.

### **New York Empire Blue Shield- Payer ID BS033**

#### **Return the Agreement to the Payer:**

**Physical address for USPS, FedEx, UPS, etc.**

EDI- Alex Jones  
Blue Shield- New York  
800 Second Ave.- Third Floor  
New York, N.Y. 10017

## EMPIRE PROVIDER AGREEMENT FOR EMPIRE HEALTHCHOICE ELECTRONIC CLAIMS SUBMISSION

This agreement shall be terminated without prior notice by Empire if abusive and/or fraudulent billing practices are uncovered.

I agree to comply with the above requirements:

Signature: \_\_\_\_\_

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

Provider Name: \_\_\_\_\_  
(Please Print Name)

Group Name: \_\_\_\_\_  
(If applicable)

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

Telephone Number: \_\_\_\_\_

Specialty: \_\_\_\_\_

INDIVIDUAL PROVIDER NUMBER: \_\_\_\_\_

\*GROUP PROVIDER NUMBER: \_\_\_\_\_  
(If applicable)

License number: \_\_\_\_\_

Vendor name: \_\_\_\_\_

CHECK ONE:

New Submitter/Provider  
Return Submitter Action Request Form

Joining an Existing Submitter  
Existing Submitter's ID #: \_\_\_\_\_

**\*An agreement must be completed by each member of the group.**

( 01/01 )