

Payer Agreement Instructions for Wisconsin Blue Shield - BS053

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 Blue Cross Blue Shield of Wisconsin Provider Services at (800) 247-7051. ProxyMed, Inc. **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 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 ProxyMed or your claims will reject.

Guidelines for completing: Wisconsin Blue Shield- Payer ID BS053

McKesson Payer Agreement Cover Sheet

Fields	Instructions
<i>All sections</i>	This form is pre-filled.

Smart Xfer TRADING PARTNER INFORMATION SHEET

Fields	Instructions
<i>IDENTIFICATION:</i>	This section is pre-filled.
<i>12 Digit Provider #:</i>	The payer does not need the doctor's individual information if the doctor is set up to send claims through a provider group. Only list the group number for the practice. Additional space has been provided on page 2.
<i>Facility Name and Address, EIN/ Tax ID:</i>	Complete all fields. Additional space has been provided on page 2.

Physical address for USPS, FedEx, UPS, etc.

McKesson

Attention: Enrollment Department

700 Locust St

Dubuque, IA 52001



Payor Agreement Cover Sheet

Agreement Type: Claims

CPID: 1401 Payor Name: Wisconsin Blue Shield – Professional

Customer ID: _____ Billing ID: _____

Submitter ID: _____

Submitter Name: _____

Customer Contact: _____ E-mail: _____

Return completed agreement to:

McKesson
Attn: Enrollment Dept. (IADU6)
700 Locust St.
Dubuque, IA 52001

McKesson Use Only:

Follow-up Date: _____

Testing required:
Provider Verification table:
Cross Reference table:
Payor assigned submitter number:

Notes: _____

_____ Last Revised on 01-20-2005

Smart Xfer TRADING PARTNER INFORMATION SHEET

Intermediary use only:
Partner Type: Claims

Date:

Completed By:

TP ID

(Production Claim Files NOT available for Direct Provider Submitters until 1/3/2005)

IDENTIFICATION

New Add

Organization:

Clearinghouse EIN/Tax ID: Current TP ID# (if known)

Contact Name: E-mail:

Phone Number: Fax Number:

Address:

City: State: Zip:

***** For additional Provider numbers please use 2nd sheet.

12 Digit Provider #	Facility Name and Address	EIN/Tax ID
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Claim Format: ANSI 837(P) ANSI 837(I) ANSI 837(D)

DATA TRANSFER INFORMATION

Connectivity: Pro Comm Plus PC AnyWhere Hyperterminal

Protocol: Zmodem Xmodem Ymodem

FTP (IVANS) FTP

Zipped: Yes No

RETURN TO: McKesson Registration Team (DBQTSHEenrollments@McKesson.com)
Fax #: 916-267-2963

Smart Xfer TRADING PARTNER INFORMATION SHEET

Pg. 2 Additional Provider Numbers

TP ID

12 Digit Provider #

Facility Name and Address

EIN/Tax ID

IF ADDITIONAL SHEETS ARE NEEDED, PLEASE COPY