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## BCBS - IOWA Wellmark

### Enrollment Instructions – Professional Claims and ERA

- ✓ **BEFORE enrolling, you MUST have a Practice Insight EDI customer account # with billing provider record added.** Please contact your EDI solutions reseller to confirm **your** EDI account setup.
- ✓ **Make sure all required information is complete and accurate.** Recheck provider numbers to be sure they are valid and accurate. Invalid or incorrect provider IDs will cause the enrollment to be delayed or rejected.
- ✓ **Keep a copy of the completed enrollment pages.** Note the date and method of submission. Keep a copy of the completed request in case you should need to follow up or resubmit.

**FAX COMPLETED REQUEST FORMS TO-  
EC Registration Dept., 1-800-691-1038**

#### **837-CLAIMS and 835-ERA Initial Provider Enrollment (New) or Re-Enrollment (Change of Service)**

If the provider has NOT submitted claims electronically to this payer or if the provider HAS SUBMITTED electronic claims to this payer VIA ANOTHER CLEARINGHOUSE, and they now want to submit via Practice Insight, the provider must complete this form:

1. Electronic Transaction Registration Form
  - a. Complete Provider Information section, list ALL Individual Providers and NPI numbers and sign. Authorized signature required.
2. Signature and Audit Agreement
  - a. Complete one copy of this form for EACH provider registering for EDI.
3. Provider Authorization For Electronic Transactions Via Third Party
  - a. Must list Group/Group NPI and list ALL Individual Providers/Individual NPIs.
4. Cancellation Request – Complete **ONLY** if for change of service; indicate submitter number of former clearinghouse/billing service and send with other forms.

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### **ALLOW 2-4 WEEKS FOR PROCESSING**

*If it has been over 30 days since request was submitted and you have not yet received confirmation of enrollment, contact your reseller or software support vendor for assistance or call BCBS IA edi dept. at 1-800-407-0267.*

# ELECTRONIC TRANSACTION REGISTRATION FORM

Electronic Commerce Solutions  
PO BOX 9232, Mail Station 4W278  
Des Moines, IA 50306-9232  
Toll Free 800-407-0267  
Fax 800-691-1038

**\*\*PROVIDER'S NPI MUST BE VALID AND REPORTED TO WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA OR SOUTH DAKOTA BEFORE YOU CAN 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 NPI)  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

Please select a method for sending your electronic transactions:  Internet Connection to INet (Web BBS) or  Dial-Up to INet

Will you be posting 835 transactions (Electronic Remittance Advice)?  YES  NO If "YES", please answer next question.

Do you have the capability to process 835 transaction (ERA)?  YES  NO

If 835 transactions (ERA) are to be received, deliver to the following submitter number: \_\_\_\_\_

## Practice Management Software

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

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

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

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

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

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

## Provider Information

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

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

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

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

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

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

**Line of Business:**  Blue Shield (Professional)  Blue Cross (Institutional)  Blue Dental  Commercial

Group Provider NPI: \_\_\_\_\_

Individual Names(s) & NPI: \_\_\_\_\_

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

For information on communications software to submit ANSI 837 electronic transactions please contact EC Solutions at 800-407-0267.

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.

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

# 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 NPI 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 NPI you need to register.

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

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

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

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

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

National Provider Identifier (NPI): \_\_\_\_\_

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

Fax to EC Registration Department at: 800-691-1038  
or mail to:  
EC Solutions  
Attention: EC Registration Department  
PO BOX 9232, Mail Station 4W278  
Des Moines, IA 50306-9232  
or email to:  
[wellmarkecsolutionsregistration@hp.com](mailto:wellmarkecsolutionsregistration@hp.com)

# 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 INet  
(Clearing House/Billing Service Submitter #)

for the following provider NPIs and names: \_\_\_\_\_,  
\_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_.

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

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

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

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

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

Email 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: \_\_\_\_\_

Fax to EC Registration Department at: 800-691-1038  
or mail to:  
EC Solutions  
Attention: EC Registration Department  
PO BOX 9232, Mail Station 4W278  
Des Moines, IA 50306-9232  
or email to:  
[wellmarkecsolutionsregistration@hp.com](mailto:wellmarkecsolutionsregistration@hp.com)

# CANCELLATION REQUEST

**Cancellation of Submitter ID Number:** \_\_\_\_\_  
Submitter Number

The cancellation of a submitter number will cause the following capabilities to cease: submission of electronic claims, retrieval of all electronic reports, and retrieval of ERA files. Reactivation of a submitter number requires a new registration form to be completed and the registration process to assign a new submitter number. This will delay your ability to send your claims electronically. Not affected are your connections to the Wellmark Internet/Web applications.

**Cancellation of PCA-AP Pro32 Software:**

The cancellation of your software will cease all support for that specific software that you have identified above. You will continue to have access to our INet system, unless you cancel your submitter number as identified above. There are no refunds!

**Using Another Vendor:** \_\_\_\_\_  
Name of New Vendor, Contact Name and Telephone Number

Electronic transactions will continue from our office via the vendor or clearing house identified above. The reports EC Solutions creates for your electronic claims are returned to the submitter number used when they are submitted. Verify you have received all your electronic reports from your previous vendor, as there may be claim rejections for you to rework.

To reinstate the above services, you must contact the EC Registration Department toll free at 1-800-407-0267.

## Required Submitter Information:

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

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

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

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

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

## Authorized Signature:

Authorized Signature: \_\_\_\_\_ Title: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_ Effective Date of Request: \_\_\_\_/\_\_\_\_/\_\_\_\_

Fax to EC Registration Department at: 800-691-1038  
or mail to:  
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