



AGREEMENT BETWEEN

BLUE CROSS & BLUE SHIELD OF MISSISSIPPI

AND

[PROVIDER]

THIS AGREEMENT made and entered into on this, the \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_, a.d., by and between BLUE CROSS & BLUE SHIELD OF MISSISSIPPI, hereinafter referred to as the "Plan" and \_\_\_\_\_, a Provider of Healthcare Services, hereinafter referred to as the "Provider".

WITNESSETH:

IN CONSIDERATION of authorizing the Provider to submit claims for healthcare services electronically by wire through the system referred to as Electronic Submission of Claims ("ESC"), the parties agree to adhere to the mutual promises and conditions set forth in the following sections::

I. TERMS

A. The Provider certifies and specifically agrees:

1. All services rendered were performed by the provider or under the Provider's supervision in its facility.

2. Authorization for payment to the Provider and for release of medical information has been fully executed by the patient. The required patient signature, or where applicable, appropriate signatures on behalf of patients, required physician certification/recertification, and PSRO certifications, where applicable, are on file and will be maintained by the Provider.

3. Properly filed source documents will be maintained by the Provider who agrees that the Plan, or its designees, have the right to audit and confirm any information submitted. Any incorrect payments which are discovered as a result of such an audit will be adjusted according to applicable provisions of the Social Security Act as amended, regulations, guidelines and provisions contained in the Plan's contracts, and Plan policy guidelines.

4. In the event the Provider engages the services of a billing agency, the Provider will notify the Plan thirty (30) days in advance, supplying the billing agency's name, address, contact personnel, and upon execution, a copy of the contract between said Provider and billing agency.



5. In the event a billing agency is authorized by the Provider to submit electronic claims in the Provider's behalf, a written contract will be secured between the two detailing the billing agency's responsibilities to report information as directed by the Provider. A copy of the contract will be furnished to the Plan. Both the Provider and the billing agency must maintain a record of all electronic claims submitted for payment.

6. Any billing agency must be authorized in writing by the Provider to submit claims, and must abide by the terms of this Agreement and enter into such an Agreement as required by the Plan. The Provider and the billing agency agree that it is their obligation to research and correct any and all billing discrepancies caused by either of them and to hold the Plan harmless for any costs or expenses, including claims overpayments or other damages incurred as a result of such billing discrepancies. The Provider and billing agency agree to hold harmless and indemnify the Plan from and against all suit or claims of liability and all damages arising from or alleged to arise from the Provider's or billing agency's negligence.

7. Access to any and all claims data will be restricted to the Provider and its employees, the billing agency and its employees, the Social Security Administration, HCFA, the Plan, or any third party as deemed necessary by the provider, so as to maintain confidentiality and to preclude the filing of fraudulent claims.

8. The Provider agrees that the submission of an electronic claim is a claim for payment and that it assumes sole liability for misrepresentation or falsification of any record or other information essential to that claim or that is required pursuant to this Agreement if such misrepresentation or falsification is made by the Provider.

9. The billing agency agrees that the submission of an electronic claim is a claim for payment and that it assumes sole liability for misrepresentation or falsification of any record or other information essential to that claim or that is required pursuant this Agreement if such misrepresentation or falsification is made by the billing agency.

10. Should a misrepresentation or falsification of any record or other information essential to any claim submitted by the Provider to the Plan via the billing agency, the Provider and billing agency agree that they shall be responsible for determining the responsible party for any misrepresentation or falsification.

11. The Provider and billing agency shall comply with the provisions of Title VI of the Civil Rights Act of 1964, as amended.

12. If it is determined by the Plan that the billing agency has violated any terms of this Agreement, it will not be authorized to act as billing agency for any provider participating in the Plan's ESC program.

## II. ELIGIBILITY

The Provider and the Plan agree that the eligibility of a subscriber obtained through the System is only an indication of the subscriber's enrollment status and benefits at the time of inquiry. Plan payment of services is contingent upon the confirmation of status at the time of Plan claims processing and upon the terms and conditions of the subscriber's contract.

## III. TRAINING

The Plan agrees to provide a reasonable amount of training to Provider's personnel at the site of Plan's choice.

## IV. TESTING

A testing phase will be a sufficient period of time so as to allow the Provider to acquire a successful transmission of at least fifty (50) claims with ninety (90%) percent accuracy.

## V. SUPPORT

A. The Plan agrees to supply the Provider with a copy of the ESC Specifications with the understanding that these specifications, in part or whole, are not to be transferred by any means to any other entity without written consent by the Plan.

B. The Plan agrees to supply the Provider with a copy of the ESC manual with the understanding that this manual, in part or whole, is not to be transferred by any means to any other entity without written consent by the Plan.

C. The Plan agrees to supply the Provider with free follow-up support for period not to exceed forty-five (45) days from the date of submission of the first test transmission, unless such support is waived by the Plan.

## VI. SYSTEM ACCESS

The Plan agrees to supply the Provider with an Access Code for ESC transmission. This Access Code is unique to each Provider and is not to be transferred by any means to any other entity without written consent by the Plan. Transmissions will be accepted only during certain time periods which are to be designated by the Plan with the understanding that these the periods may be altered by the Plan with prior notice given to Provider.

## VII. COST

A. Any and all costs incurred during the designing, implementation, etc., of the Provider ESC system will be the responsibility of the Provider. However, if the Plan intends to bill the Provider for any cost, those costs will be identified and approved by the Provider in advance.

B. Any and all telephone costs for access lines used by the Provider for ESC transmission will be the responsibility of the Provider, unless otherwise designated or waived by the Plan.

## VIII. ENTIRE AGREEMENT

This Agreement, including its attached Provider Identification Worksheet, shall constitute the entire Agreement between the Provider and the Plan for the equipment, services and functions addressed in the Agreement, and may only be amended by a separate writing mutually agreed to by both parties. However, notwithstanding the foregoing, it is expressly agreed that any Participating Provider Agreement between the Plan and the Provider shall remain in full force and effect, separate and apart from the Agreement, and this Agreement shall not act to modify or alter the terms of that Agreement.

## IX. CONTROLLING LAW

This Agreement shall be governed by the Laws of the State of Mississippi.

## X. TERMINATION

Either party may terminate this Agreement by giving thirty (30) days prior written notice to the other party.

THIS AGREEMENT is effective on and after \_\_\_\_\_  
and shall continue in full force and effect until termination with or without cause by either party.

BLUE CROSS BLUE SHIELD  
OF MISSISSIPPI

\_\_\_\_\_  
PROVIDER NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
PRINTED NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Signature Claims (S2964ZC)  
BILLING AGENCY NAME

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
William C. Greenland  
PRINTED NAME

\_\_\_\_\_  
DATE

**Please remit to:**

Blue Cross Blue Shield of Mississippi  
ATTN: EDI Services  
P.O. Box 1043  
Jackson, MS 39215-1043  
Fax - 601.936.5886



**ELECTRONIC CLAIMS INFORMATION  
Worksheet**

<b>PROVIDER INFORMATION (PLEASE PRINT)</b>	
Provider Name	
Facility Name	
Address	
City, State, ZIP	
Contact Name	
Email Address	
Telephone	Fax

<b>IDENTIFICATION NUMBERS</b>	
TAX ID	Provider ID
Provider ID	Provider ID
Provider ID	Provider ID
Provider ID	Provider ID
Provider ID	Provider ID
Provider ID	Provider ID
Provider ID	Provider ID