P.O. Box 7011 Northridge, Ca 91327-7011 * (818) 368-5501 * www.signatureclaims.net

Provider Sign-up Form Information

Blue Cross/ Blue Shield Central Pennsylvania (Capital)

Fill in the first line.
If you want Electronic Remittance Advice, then check the section called "**Receive Electronic Remittance Advice via HIPAA Compliant ANSI 835**". You will receive your ERA from Signature Claims. NOTE: This often will END your paper EOBs.

Finish filling out the form with your provider number(s)

Sign the bottom

Complete and mail this form to:
Capital Blue Cross
EDI-Enrollment
2500 Elmerton Ave
Harrisburg, PA 17177-4138

Capital BlueCross/Capital Advantage Insurance Company
Electronic Data Interchange (EDI) Agent Designation Form

This is to advise Capital Blue Cross and its wholly owned affiliates that ____ (Provider Name) has appointed ___Signature Claims (4204)_____________________________(Agent Name) as our agent for the following purposes:

(Please check all that apply for Capital BlueCross purposes):

- X Submission of Professional claims via HIPAA Compliant ANSI 837
- ☐ Submission of HIPAA compliant ANSI 270/271 (Eligibility) transactions
- ☐ Submission of HIPAA compliant ANSI 276/277 (Claim Status) transactions
- ☐ Receive Electronic Remittance Advice via HIPAA Compliant ANSI 835
- ☐ Submission of HIPAA compliant ANSI 278 (Health Services Review) transactions
- ☐ Other (Describe below)

Description of Agency – What will the Agent do on behalf of the Provider?
Purposes:__**Clearinghouse-Submitter**____

____

List Provider Numbers Covered by this Agency Agreement:

____

____

List National Provider Identifier (NPI) Numbers Covered by this Agency Agreement:

{Please provide Type 2 – Organization NPI(s), not Type 1 – Individual NPI(s)}

____

____

Capital BlueCross is authorized to treat the Agent as though it was the Provider for the purposes noted above.

The Provider understands that Capital BlueCross will be relying on this representation for claims processing purposes and for purposes of releasing confidential information. Provider confirms that the Agent has signed a written agreement pursuant to which it has agreed to treat any information that it receives from Capital BlueCross as confidential, and in accordance with all applicable laws and regulations.

Further, in consideration of Capital BlueCross' acceptance of the Agent, the Provider agrees that it will indemnify and hold Capital BlueCross harmless for any and all damages, claims and expenses that Capital BlueCross may incur or that may be asserted against Capital BlueCross as a result of the negligent or intentional actions of the Agent in carrying out its duties in connection with the purposes noted above.

Capital BlueCross shall be entitled to rely on this letter until revoked in writing.

Provider understands that Capital BlueCross reserves the right to modify its policies relating to the release of confidential information, including the release of subscriber information to providers or their agents, at any time.

Signature: ___________________________________ **Phone #:** ____________________
(Must be an Officer of the Provider)

Print Name: __________________________________ **Email:** ______________________

Title: ___________________________________ **Date:** ______________________

Health care benefit programs issued or administered by Capital BlueCross and/or its subsidiaries, Capital Advantage Insurance Company ® and Keystone Health Plan ® Central. Independent licensees of the Blue Cross and Blue Shield Association. Communications issued by Capital BlueCross in its capacity as administrator of programs and provider relations for all companies.