



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

Provider Sign-up Form Information

Emdeon/Value Options

Complete ALL forms.

Email ALL forms to:

batchenrollment@emdeon.com

Send a copy to:

admin@signatureclaims.net

Emdeon **Claims** Provider Setup Form

Email: batchenrollment@emdeon.com

Fax: (615) 885-3713

1 Provider Organization

Practice/Facility Name							
Provider Name							
Provider Specialty Code		Tax ID		Site ID			
Practice/Facility Provider Address		Street					
		City		State		Zip Code	
Contact Name				Contact Phone Number			

2 Vendor (Emdeon Certified Vendor used to submit files to Emdeon)

Vendor Name							
Vendor Submitter ID							
Contact Name				Contact Phone Number			

3 Report Method

TSO ID		Communication Protocol/Output					
Report Type				Report Format			
Repository Report Options.pdf Human Read Specs.pdf							

4 Payer

M = Medical Commercial Only H = Hospital Commercial Only

Please list additional payers below

Check the Emdeon Payer List to see if additional enrollment is required at: <http://www.emdeon.com/PayerLists/payerlists.php>

Payer ID	Group ID	Individual ID	NPI ID	Payer ID	Group ID	Individual ID	NPI ID

5 Confirmations (Enter E-mail address)

Confirmations (Enter E-mail address)

PAYER ID:

SUBMITTER ID:



emdeon™

Emdeon **Claims** Provider Information Form

*This form is to ensure accuracy in updating the appropriate account

1 Provider Organization					
Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
2 Vendor <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					
3 Payer					
Payer ID					
Group ID	Individual Provider ID		NPI ID		
4 Confirmations					
Send Emdeon Claim Confirmations To:					
Special Instructions:					
<ul style="list-style-type: none"> All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted. SUBMIT COMPLETED FORM TO: Fax: (615) 231-4843 Email: batchenrollment@Emdeon.com 					
EMDEON REVISION FORM DATE:					



Online Provider Services
Account Request Form

Required fields are marked with an asterisk. *
Fax pages 1 & 2 of completed form to 866-698-6032.
Questions on this form? Call 888-247-9311 or see
instructions on page 3.

- Special Instructions:
[] Secondary/Billing Clerk Account
[] Group Practice Account
[] SX173

*Provider, Practice or Facility Name

ValueOptions assigned Provider ID. If not known, please
contact the correct provider contacts on page 3

*National Provider Identifier # (NPI)

*Provider, Practice or Facility Tax ID (do not include the dash)

*Address Line 1

Address Line 2

*City

*State

*Zip Code

()
*Telephone Number

()
Fax Number

*Please check which Online Provider Services options you would like to have access to:

- [] Electronic Batch Claims Submission (Claim batch file uploads)
[] Single Claims Submission (Directly on website)
[] Eligibility Inquiry
[] Claim Status Inquiry
[] Authorization Inquiry

*Provider named above or office staff will be submitting claims [] Yes [] No (N/A if only requesting inquiry status)

Provider has retained a 3rd party Billing Agent or Clearinghouse to submit claims on their behalf. (Other than office staff) (If yes, please complete the Billing Intermediary Authorization Form) [] Yes [] No

Depending on the state in which you are practicing, you may need multiple accounts created to ensure the claims are processed accurately (i.e. Medicaid vs. Commercial). Therefore, to help us in setting up your account(s) correctly, if you are located in...

- Colorado, will you be submitting CO Medicaid Claims? [] Yes [] No, Commercial Only [] Both
Kansas, will you be submitting either KS Medicaid Claims or AAPS Block Grant Claims? [] Yes [] No, Commercial Only [] Both
Massachusetts, will you be submitting MBHP Claims? [] Yes [] No, Commercial Only [] Both
New Mexico, will you be submitting NM Medicaid Claims? [] Yes [] No, Commercial Only [] Both
Pennsylvania, will you be submitting SWPA Medicaid Claims? [] Yes [] No, Commercial Only [] Both
Pennsylvania, will you be submitting for the Non-HealthChoices Mental Health Program? [] Yes [] No Counties:
Texas, will you be submitting TX NorthSTAR Claims? [] Yes [] No, Commercial Only [] Both

* Provider's Contact e-mail address

E-mail address where you would like to receive your batch submission file feedback.

*Contact Name



Online Provider Services
Account Request Form

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instructions on page 3.

Agreement Terms:

- A. The undersigned submitter authorizes ValueOptions to receive and process claims via the ValueOptions Electronic Transport System (ETS) or ValueOptions Online Provider Services Program on his/her/its behalf in accordance with the applicable regulations.
- B. All submitted information must be true, accurate and complete. I/We understand that payment of any claim submitted in falsification or concealment of a material fact may be prosecuted under any applicable state and/or federal laws.
- C. The Submitter agrees to comply with any laws, rules and regulations governing the ValueOptions Online Provider Services/EDI program.
- D. The Provider agrees to accept, as payment in full, the amounts paid in accordance with the fee schedules provided for under previously established agreements with ValueOptions.
- E. This is to certify that an exact copy of any claim files submitted via the ValueOptions ETS system or Online Provider Services program will be stored in an electronic medium and held by the originator for a period of 90 days or until the submission has been finalized as to reimbursement or denial of payment, whichever comes first.

*This is to certify that the following is true:

I am a provider
OR
 I am office staff of a Provider, and am authorized to sign on their behalf.

Signatures:

_____ Title of individual signing for organization
_____ Legal name of Organization (please print or type)

_____ *Date
_____ *Authorizing Signature
_____ *Name of Individual Signing for Organization



**Online Provider Services
Account Request Form**

Required fields are marked with an asterisk. *
Fax pages 1 & 2 of completed form to 866-698-6032.
**Questions on this form? Call 888-247-9311 or see
instructions on page 3.**

Instructions for Account Request Form

The following information should be helpful with certain information we requesting on this form.

Secondary/Billing Clerk account?

If a ProviderConnect account already exists for the provider or facility, and an office staff member needs their own unique ID/password, you can check this box.

Group Practice Account?

- If you bill using several individual unique provider numbers, we will need a copy of this form for each provider, and you can check this box.
- If you bill as the facility using only a single provider ID, we only need one copy of this form.

Provider ID number:

To make sure you have the correct provider ID numbers, and depending on what state and type of claims you will be submitting, the following service centers will be able to best assist you:

For all commercial accounts or states not listed below: 800-397-1630

Arizona Medicaid: 800-747-7140

Colorado Medicaid: 800-397-1630

Massachusetts MBHP: 800-495-0086

New Mexico Medicaid: 888-251-7511

Pennsylvania SWPA Medicaid: 800-397-1630

Pennsylvania Non-HealthChoices Mental Health Program: 800-397-1630

Texas NorthSTAR: 800-397-1630

Batch vs. Single Claim Submission:

Single Claim Submission: If you are a smaller practice, or happen to have a low volume of Professional claims (normally submitted on a HCFA-1500 or CMS-1500), Single Claim Submission may be best and easiest. With this option, you can submit each claim directly on the website, the member and provider information are verified, and you receive a claim number right away.

Batch Claim Submission: If you have to submit Institutional claims (submitted on a UB-92 or UB-04 form), and/or if you have a larger volume of Professional Claims, you can select Batch Claim submission. With this feature, you will create your claims using either our EDI Claims Link Software, or your own practice management software. You will then upload a batch file via our website for processing. Claim numbers are usually available in about 1 business day.

You can select both Batch Claim and Single Claim Submission if you like.

Commercial and Medicaid Claims:

We may need to create more than one online account for you if you need to submit both commercial and Medicaid claims.

If you only select commercial or Medicaid for now, and you need to add the other in the future, please contact the EDI Helpdesk and we can make the appropriate updates for you.



Online Provider Services
Intermediary Authorization Form

Required fields are marked with an asterisk. *
Please fax completed form to 866-698-6032.
Questions on this form? Call 888-247-9311 (option 3)

INSTRUCTIONS:

This form should be completed by providers who contract with a third party to submit claims. If the Billing Intermediary will submit claims for multiple providers, an Account Request Form and an Intermediary Authorization Form is required for each provider.

Billing Agent/Clearinghouse/Intermediary Information

Provider Information:

EMDEON

*Billing Intermediary Name

*Provider Name

EMDEON

*Billing Intermediary's Submitter ID (if already established)

*Provider NPI number

JAMES CARNEY

*Contact name at billing intermediary

ValueOptions assigned provider ID number

PAYERREGISTRATION@EMDEON.COM

*Email address at billing intermediary

800-845-6592

*Phone number at intermediary

*Please check those options for which you have been authorized by the below-signed provider.

- [X] Electronic Claims Submission [] Single Claims Submission [] Online Eligibility Inquiry [] Online Claim Status Inquiry [] Authorization Inquiry

Agreement Terms:

- A. The undersigned Provider Authorizes the above Billing Intermediary to submit claims to ValueOptions on his/her/its behalf in accordance with any applicable regulations.
B. The provider warrants that he/she/it has entered into a written agreement with above named Billing Intermediary. The provider understands and agrees that its use of this Billing Intermediary does not in any manner relieve the provider of full responsibility and liability for any violations of the laws, regulations and rules which govern the ValueOptions EDI program.
C. The provider accepts full liability for all actions of the above named Billing Intermediary within its actual or apparent authority to act on behalf of the provider, notwithstanding any contrary provisions in the agreement between the provider and the Billing Intermediary. In the case of any violations of applicable laws, rules and regulations governing the ValueOptions EDI program, which arise out of the actions of the Billing Intermediary, the provider accepts full liability as though these actions were the provider's own actions.
D. The provider agrees to notify ValueOptions in writing at least ten (10) days prior to the effective date of the revocation of this Intermediary Authorization Form. In such event, the provider's liability for the acts of the Billing Intermediary will continue until the tenth day after the receipt of such notification or the effective date of the revocation, whichever is later.

Signatures: Carla Sheffield

*Billing Intermediary's Signature

*Provider or provider's staff signature

Date

Date