

**NEW JERSEY BCBS MEDICAL****For Initial Enrollment with this payer:**

- If you have NOT submitted claims electronically to this payer, the Payer requires Payer Registration forms. Please complete all fields on the following page(s) as well as the attached Payer Registration forms and return to Emdeon for processing.
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site <http://www.emdeon.com>. or by calling our Fax on Demand service at 800-760-2804 (doc# 1083)

For Re-Enrollment (COS Change of Service) with this payer:

- If you have submitted claims electronically to this payer in the past, either directly or through another clearinghouse, and would like to submit through Emdeon, the Payer requires payer registration forms.
- Registration with Emdeon takes 14 business days.
- Your Payer Registration form must include a valid Provider ID. Listing an invalid Provider ID will delay the process.
- This payer accepts group agreements.
- You may obtain the form from our enrollment web site <http://www.emdeon.com>. or by calling our Fax on Demand service at 800-760-2804 (doc# 1083)

If you are already APPROVED by this payer to submit through Emdeon:

- If you have already received an approval from this payer to submit claims electronically through Emdeon, you must notify Emdeon so that we may process your approval in our enrollment systems. Please submit a **Client Provided Approval Form** to Enrollment for processing.
 - You may obtain the form from our enrollment web site <http://www.Emdeon.com>. or by calling our Fax on Demand service at 1-800-760-2804 (doc# 1450).
 - The Client Provided Approval form must be submitted to: payerregistration@Emdeon.com , or faxed to 615-885-3713.

Payer Registration Reminders:

- Please keep a copy of all forms for your records.
- Please verify that all pages in the agreement are included when mailing.
- Please ensure that all required fields are completed and legible.
- Please provide a physical address below in case we need to Fed-Ex your agreement back to you.
- Please remember to sign and date all documents. Your software vendor must be certified to send All-Payer claims to Emdeon. Please contact your vendor if you have questions regarding certification.
- To obtain forms or additional payer information, visit our website: <http://www.Emdeon.com>.


NEW JERSEY BCBS MEDICAL
Instructions for submitting Payer Registration Forms:

- You must include this page when submitting Payer Registration forms to Emdeon
- Registration forms must be submitted to the address below
- To obtain forms or additional payer information, visit our website: <http://www.Emdeon.com>.

This Registration form is for a:			
		<input type="checkbox"/> Provider	<input type="checkbox"/> Group
Name*			
Physical Address*			
City, State, Zip*			
Contact Name*			
Contact Phone			
Contact Fax			
Contact Email Address [§]			
<input type="checkbox"/> NPI ID*		<input type="checkbox"/> Group ID*	
		<input type="checkbox"/> Provider ID*	
<input type="checkbox"/> Tax ID* <input type="checkbox"/> SSN		Site ID*	
Vendor Submitter ID*		Division ID*	
Vendor Name*			
Additional Info			

* Required Information if applicable.

[§] All Approval Notifications will be sent to this address

Submit Original Payer Registration forms that require original signatures to:

Emdeon Business Services
 Attn: Enrollment Dept
 Donelson Corporate Ctr Bldg 3
 3055 Lebanon Pike Ste 2000
 Nashville, TN 37214

For all other forms:

Fax: (615) 231-4843

Email: batchenrollment@Emdeon.com

To avoid claim rejection, please do not submit electronic claims before receiving **Emdeon Approval Notification**.

ELECTRONIC TRANSACTION AUTHORIZATION

Health Care Professional, Hospital, Facility or Trading Partner Name: _____

Address: _____

City: _____ State: _____ Zip code: _____

Contact: _____

Phone: _____ Fax: _____

E-mail Address: _____

Tax ID: _____ Hospital and Facility Number: _____
 (Required for Hospital, Facility, Physician & Other Health Care Professional) (Required for Hospital and Facility only)

Alpha Suffix(s) _____
 (Required for Multispecialty Groups with assigned suffix)

Mode of Transmission:

Please check only one.

<u>Specific to:</u>	<u>Rules and Regulations</u>
<input type="checkbox"/> <u>HorizonNet 2000</u> <u>Or</u> <input type="checkbox"/> <u>*Software Vendor</u>	In the case that we use HorizonNet 2000, we agree to authorize Horizon Blue Cross Blue Shield of New Jersey access to our Horizon BCBSNJ Electronic Submission ID for installation on our computer. In the case that we use a software vendor, we agree to authorize our software vendor access to our Horizon BCBSNJ Electronic Submission ID for installation on our computer. We agree to maintain the confidentiality of our Submission ID and Password and prevent unauthorized users from committing data security violations with our Submission ID and Password. We realize that it is our responsibility to retrieve any and all reports that are put in our electronic mailbox by Horizon BCBSNJ detailing the results of our transmission(s). We agree to notify Horizon BCBSNJ if we discontinue sending electronic transmissions through HorizonNet 2000 or the below named software vendor and before beginning to use any other Trading Partner to send electronic transmissions.
<input checked="" type="checkbox"/> <u>*Clearinghouse</u> <u>Or</u> <input type="checkbox"/> <u>*Billing Service</u>	We agree to authorize the billing service or clearinghouse named below to submit our Horizon BCBSNJ claims electronically. We realize that it is our responsibility to assure that we receive from our billing service or clearinghouse any and all reports that are sent electronically from Horizon BCBSNJ to our billing service or clearinghouse detailing the results of our transmission(s). We agree to notify Horizon BCBSNJ if we discontinue sending electronic transmission through the below named trading partner and before beginning to use any other trading partner to send electronic transmissions.
<input type="checkbox"/> <u>Hospital, Facility, Physician or Other Health Care Professional Programming Horizon BCBSNJ Specification</u>	We agree to fully program all aspects of the Horizon BCBSNJ Specification for the transactions we desire to send electronically to assure accurate and complete data transmission. We agree to program all transaction specific edits as outlined in the Horizon BCBSNJ Specification to assure a limited number of rejects. We agree to make all programming changes requested by Horizon BCBSNJ as promptly as reasonably possible. We agree to maintain the confidentiality of our Test and Production Submission IDs and Passwords and prevent unauthorized users from committing data security violations with our Submission IDs and Passwords. We realize that it is our responsibility to retrieve any and all reports that are put in our electronic mailbox by Horizon BCBSNJ detailing the results of our transmission(s). We agree to notify Horizon BCBSNJ if we discontinue sending electronic transmissions and before beginning to use other means of electronic transmissions.

*If you checked Software Vendor, Clearinghouse or Billing Service (“Trading Partner”), please provide the name of your software vendor, clearinghouse, or billing service below:

Name of Trading Partner: _____

