

**NEW YORK BCBS MEDICAL (EMPIRE)****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.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies are accepted.
- Registration with Emdeon takes 28 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# **1111**)

**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.
- All Payer Registration forms must contain original signatures in **BLUE INK**, no stamped signatures or photocopies are accepted.
- Registration with Emdeon takes 28 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# **1111**)

**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](mailto: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 YORK BCBS MEDICAL (EMPIRE)**
**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 <sup>§</sup>			
<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.

<sup>§</sup> 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](mailto:batchenrollment@Emdeon.com)

**To avoid claim rejection, please do not submit electronic claims before receiving [Emdeon Approval Notification](#).**



800 Second Avenue, 3<sup>rd</sup> Floor, New York, NY 10017

## **EMPIRE PROVIDER AGREEMENT FOR EMPIRE BLUE CROSS BLUE SHIELD ELECTRONIC CLAIMS SUBMISSION**

This agreement is between "Provider," a licensed provider or supplier of health services, and Empire, as to rights and obligations pertaining to automated submission and processing of Empire Blue Cross Blue Shield claims, as follows:

1. The Provider agrees that Empire, its agents and subsidiaries, shall have the right to audit and confirm any information submitted by Provider or its billing service, and shall have access to and may obtain copies of all original source records and medical records related to any claim, at no cost to Empire, including patient authorizations. Any incorrect payments which are discovered as a result of such an audit will be adjusted as may be appropriate according to applicable Empire procedures.
2. The Provider shall research and correct any and all billing discrepancies attributable to Provider or its billing service and use due diligence in reviewing reconciliation documents.
3. The Provider shall ensure that every automated bill is capable of being associated and identified with a source record and a patient authorization in such form as may be required by Empire.
4. The Provider shall maintain all original source records, authorizations and medical records pertaining to any particular claim for a period of six (6) years following the month of payment or rejection by Empire. In the event of an audit, the Provider shall fully comply with requests for documentation associated with submitted claims, either pending or finalized.
5. The Provider shall repay Empire for all payments made for services not supported by source documents and medical records.
6. The Provider shall submit bills in accordance with Empire rules and regulations at the time and accept full responsibility for knowledge of said policies.
7. The Provider shall accept responsibility for all claims submitted to Empire by Provider, its billing service or any other agent.
8. Empire shall keep the Provider apprised of its rules and regulations pertinent to automated billing.
9. The Provider is responsible for the conduct of any billing service involved in a case where claims are submitted through or by such billing service.

# EMPIRE PROVIDER AGREEMENT FOR EMPIRE BLUE CROSS BLUE SHIELD ELECTRONIC CLAIMS SUBMISSION

This agreement shall be terminated without prior notice by Empire if abusive and/or fraudulent billing practices are uncovered.

I agree to comply with the above requirements:

Signature: \_\_\_\_\_

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

Provider Name: \_\_\_\_\_  
(Please Print Name)

Group Name: \_\_\_\_\_  
(If applicable)

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

Telephone Number: \_\_\_\_\_

Specialty: \_\_\_\_\_

INDIVIDUAL PROVIDER NUMBER: \_\_\_\_\_

\*GROUP PROVIDER NUMBER: \_\_\_\_\_  
(If applicable)

License number: \_\_\_\_\_

Vendor name: \_\_\_\_\_ Emdeon \_\_\_\_\_

CHECK ONE:

New Submitter/Provider  
Return Submitter Action Request Form

Joining an Existing Submitter  
Existing Submitter's ID #: 007903

**\*An agreement must be completed by each member of the group.**