Wellmark®

Electronic Transaction Registration Packet

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REGISTRATION INSTRUCTIONS

Please note that a valid provider NPI is required in order to complete the ANSI 837 Electronic Transaction Registration Form.

The registration form may be used to request a submitter number for submitting electronic claims using Web BBS or to add a provider to an existing submitter number.

This registration form is applicable for Wellmark Blue Cross and Blue Shield, Blue Dental and applies to any of the following ANSI Transactions: 837, 270, 276, 278 and 820. NOTE: Employer groups offering Wellmark coverage need to complete a different registration form to submit electronic membership/enrollment transactions. See the "Electronic Membership Enrollment Registration Form (834)" by selecting About Wellmark > For Employers.

- **Web Bulletin Board System (Web BBS) Access**
  Do you wish to start submitting electronic claims using Web BBS?
  In order to submit electronic claims through Web BBS the ANSI 837 Electronic Transaction Registration Form must be completed. The Signature and Audit Agreement must also be completed. One Signature and Audit Agreement per provider NPI is required for electronic claim submissions. Individuals authorized to sign the Signature and Audit Agreement would include an office manager or office administrator with authority to sign for the provider, doctors or facility.

- **Add provider NPI(s) to your existing Submitter ID**
  Already submitting electronic claims through Web BBS and simply wish to add a new provider(s) to an existing submitter ID?
  Current submitters of electronic claims through Web BBS must complete the ANSI 837 Electronic Transaction Registration Form in order to register a new provider under an existing submitter ID. One Signature and Audit Agreement per provider NPI is required.

Once the registration form is completed:

- Fax the completed registration form to the EC Registration Department at **800-691-1038.** Or email to: wellmarkecsolutionsregistration@dxc.com.

- The registration process takes approximately 10 business days to complete from the time the registration form is received by EC Registration Department.

- To start submitting electronic claims using Web BBS, a security letter containing submitter ID, Web BBS ID and Web BBS Password Security will be mailed to the address listed on the registration form under "Submitter Address."

- To add a provider number to an existing submitter ID, an email will be sent from EC Solutions Registration Department to the person listed in the "Contact" field of the registration form. If an email address is not listed, a phone call will be placed. The email or call is to confirm the provider NPI(s) is ready to submit electronically.

SUBMITTER: refers to the party that will be sending the claims electronically to Web BBS. This may be a billing service, clearinghouse, or provider.
PROVIDER: refers to the facility or physician providing the healthcare services. Please use the clinic name if different from the doctor's name.
VENDOR: refers to the company that supports your electronic claims submission software. If you design your own software, you are the vendor.

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ELECTRONIC TRANSACTION REGISTRATION FORM

Electronic Commerce Solutions
PO BOX 9232, Mail Station 4C103
Des Moines, IA 50306-9232
Toll Free 800-407-0267
Fax 800-691-1038

PROVIDER'S NPI MUST BE VALID AND REPORTED TO WELLMARK BLUE CROSS AND BLUE SHIELD OF IOWA OR SOUTH DAKOTA BEFORE YOU CAN REGISTER*

Submitter Name: _____

Contact: _____ Title: _____

Phone: (_____)_____ Fax: (_____)_____

Submitter Address 1: _____

Submitter Address 2: _____

City: _____ State: _____ Zip Code: _____

County: _____ Email Address: _____

Do you already have a submitter ID? **(This is separate from your provider NPI)** ☐ Yes ☐ No

If yes, what is your Submitter ID? _____

As a result of HIPAA regulations, we need to know if you provide clearinghouse services for electronic transactions. ☐ **Yes** ☐ **No**

If you are interested in receiving the 835 transaction (Electronic Remittance Advice) or EFT (Electronic Funds Transfer) you will need to go to Wellmark.com to access these forms. The ERA and EFT enrollment forms are secured which will require **providers** to register for Wellmark.com.

Practice Management Software

Vendor Name: _____

Address 1: _____

Address 2: _____

City: _____

State: _____ Zip Code: _____

Phone: (_____)_____

Provider Information

Provider Name: _____

Address 1: _____

Address 2: _____

City: _____

State: _____ Zip Code: _____

Phone: (_____)_____

Tax ID: _____

Group Provider NPI: _____

_____

Individual Names(s) & NPI: _____

_____

_____

If additional space for provider NPIs and names is needed, please attach a list to this agreement.

For information on communications software to submit ANSI 837 electronic transactions please contact EC Solutions at 800-407-0267.

Please complete and sign the registration form. The signature (located at the bottom of the form) must be from a provider or an office administrator authorized to sign on behalf of the doctors or facility.

Authorized Signature /Date **(REQUIRED)** _____ Date _____/_____/_____

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SIGNATURE AND AUDIT AGREEMENT

WE (I) hereby authorize Wellmark Blue Cross and Blue Shield, acting on their own behalf or as fiscal agents for the administration of Title XVIII in Iowa or as agents of Blue Dental Plan and Pharmacy Service Corporation access to patients' files to:

1) Verify that valid patient authorizations are received and maintained for claims submitted from the office, when applicable.

2) Verify the validity and accuracy of the claims submitted.

In submitting machine readable claims, WE (I) understand that WE ARE (I AM) certifying that the required patient signatures, or, where applicable, appropriate signatures on behalf of the patient, and required physician certifications and re-certifications (PSRO certifications where applicable) are on file and that anyone who misrepresents or falsifies essential claims information, may, upon conviction be subject to fine and imprisonment under Federal law.

In the event that payment information is returned in machine-readable form, WE (I) understand that this information will cover all claims paid to this provider NPI whether they were submitted on paper or in machine readable form.

- Patient Authorizations (signatures) are not required for non-patients.
- Please photocopy this page for each provider NPI you need to register.

Signed: _____

Provider Name: _____

Address 1: _____

Address 2: _____

City, State and Zip Code: _____

Tax ID: _____

National Provider Identifier (NPI): _____

Date: _____/_____/_____

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
PO BOX 9232, Mail Station 4C103
Des Moines, IA 50306-9232
or email to:
wellmarkecsolutionsregistration@dxc.com

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PROVIDER AUTHORIZATION FOR ELECTRONIC TRANSACTIONS VIA THIRD PARTY

I, _____, _____,
(Administrator/Officer) (Title)

representing _____ submitter number _____
(Provider Office Name) (Provider Submitter # if Applicable)

authorize _____,
(Clearing House/Billing Service)

submitter number _____ to submit my electronic claims to Web BBS
(Clearing House/Billing Service Submitter #)

for the following provider NPIs and names: _____, _____, _____

,_____, _____, _____, _____, _____, _____.

If additional space for provider NPIs and names is needed, please attach a list to this agreement.

Provider Office Name: _____

Provider Address: _____

City, State and Zip Code: _____

Phone: (_____)_____ Fax: (_____)_____

Email Address: _____

_____ _____/_____/_____
(Signature of Administrator in Provider Office) (Signed Date)

Fax to EC Registration Department at: 800-691-1038
or mail to:
EC Solutions
Attention: EC Registration Department
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SUBMITTER CHANGE OF ADDRESS REQUEST FORM

This form needs to be completed for any address changes or company name changes. Company name changes need to be accompanied by a letter on your company's letterhead stating the old name and current name.

Old Information

Submitter Number: _____

Facility Name: _____

Contact Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____ Fax: (_____)_____

Email Address: _____

New Information:

Submitter Number: _____

Facility Name:_____

Contact Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

Email Address: _____

Fax to EC Registration Department at: 800-691-1038
or mail to:
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CANCELLATION REQUEST

☐ **Cancellation of Submitter ID Number:** _____
Submitter Number

The cancellation of a submitter number will cause the following capabilities to cease: submission of electronic claims, retrieval of all electronic reports, and retrieval of ERA files. Reactivation of a submitter number requires a new registration form to be completed and the registration process to assign a new submitter number. This will delay your ability to send your claims electronically. Not affected are your connections to the Wellmark Internet/Web applications.

☐ **Cancellation of PCA-AP Pro32 Software:**

The cancellation of your software will cease all support for that specific software that you have identified above. You will continue to have access to our Web BBS system, unless you cancel your submitter number as identified above. There are no refunds!

☐ **Using Another Vendor:** _____
Name of New Vendor, Contact Name and Telephone Number

Electronic transactions will continue from our office via the vendor or clearing house identified above. The reports EC Solutions creates for your electronic claims are returned to the submitter number used when they are submitted. Verify you have received all your electronic reports from your previous vendor, as there may be claim rejections for you to rework.

To reinstate the above services, you must contact the EC Registration Department toll free at 1-800-407-0267.

Required Submitter Information:

Submitter Name: _____

Address: _____

City: _____ State: _____ Zip Code:_____

Phone: (_____)_____ Fax: (_____)_____

Email Address: _____

Authorized Signature:

Authorized Signature: _____ Title: _____

Printed Name: _____

Date Signed: _____/_____/_____ Effective Date of Request: _____/_____/_____

Fax to EC Registration Department at: 800-691-1038
or mail to:
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Attention: EC Registration Department
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