400 Vermillion Street • Hastings, MN 55033
Ph 800-482-3518 • Fax 651-389-9152
www.edsedi.com

WELLMARK
IOWA BLUE DENTAL
BLUE CROSS BLUE SHIELD OF SOUTH DAKOTA
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION

PAYER ID NUMBER	**CBIA1 - Blue Cross of Iowa (FEP Claims Only)** **CBIA2 - Blue Cross of Iowa** **CBSD1 - Blue Cross Blue Shield of South Dakota (Including FEP)**
SPECIAL NOTES	• The enrollment process takes approximately three weeks to complete. • Wellmark will only allow Providers who reside or practice in the state of Iowa or South Dakota to submit claims electronically. • Wellmark willNOT allow non-participating providers of the Wellmark BCBS Program of Iowa or South Dakota to submit claims electronically and must submit on paper. • If you are unsure of your status as a Wellmark BCBS of Iowa or South Dakota member, please call 800-407-0267. • Wellmark will not process your enrollment unless the provider is already credentialed. If the provider is not credentialed, please contact Provider Services at (800)708-1342.
ELECTRONIC REGISTRATIONS Agreements Required	**EDS Provider Enrollment Form** • Please complete all requested information **Electronic Transaction Enrollment Form** • Fill in the Practice Management Software Vendor name, address & Phone number • Fill in the Provider name, address & phone number. • Fill in the Group NPI Provider Number & each Individual Name and Rendering NPI Provider Number(s). • Sign and date at the bottom of the form ***(REQUIRED)*** **Signature and Audit Agreement** ***YOU NEED TO PHOTOCOPY & FILL IN THIS PAGE FOR EACH PROVIDER NUMBER YOU ARE ENROLLING.*** • Fill in the Signature, the Provider Name, Address, Rendering NPI Provider Number and Date. **Change of Address Request** • This form needs to be completed for any address change or company name change. Company name changes need to be accompanied by a letter on your company's letterhead stating the old name and current name.
SEND ENROLLMENT FORMS TO:	Electronic Dental Services 400 Vermillion Street, Suite 8 Attn: Enrollment Hastings, MN 55033 E-mail: Enrollment@edsedi.com or Fax: 651-389-9152
ENROLLMENT CONFIRMATION	• Enrollment will be coordinated between EDS and Wellmark. • The enrollment process takes approximately 14-21 business days.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently receives claims through another Billing Agent other than Electronic Dental Services each Provider must re-enroll following the procedures listed above.
CONTACT PHONE NUMBERS	Wellmark Provider Enrollment 800-407-0267 Electronic Dental Services 800-482-3518

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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **WellMark - Payer IDs: CBIA1, CBIA2 and CBSD1**

Provider/Organization Name: _____

Tax Identification or Social Security Number:_____
(Number that will be used to submit electronic claims)

Software Vendor/Clearinghouse: **Electronic Dental Services (EDS)**

Group NPI Number:_____
(if applicable)

Rendering

Name	NPI
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Address: _____

City, State, Zip Code:_____

Office Contact Name:_____

Telephone Number:_____ Fax Number:_____

Date:_____

ELECTRONIC TRANSACTION REGISTRATION FORM

Electronic Commerce Solutions
PO BOX 9232, Mail Station 4W321
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: Claims Processing Service, Inc. dba Emdeon Business Services
Contact: Provider Enrollment Group Title: Customer Service Reps.
Phone: (888) 255-7293 Fax: (860) 289-0055
Submitter Address 1: 220 Burnham St
Submitter Address 2:
City: South Windsor State: CT Zip Code: 06074
County: Hartford Email Address: dentalsupport@emdeon.com
Do you already have a submitter ID? **(This is separate from your provider NPI)** [X] Yes [ ] No
If yes, what is your Submitter ID? 704
As a result of HIPAA regulations, we need to know if you provide clearinghouse services for electronic transactions. [X] **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	**Provider Information**
Vendor Name:	Provider Name:
Address 1:	Address 1:
Address 2:	Address 2:
City:	City:
State: Zip Code:	State: Zip Code:
Phone: ( )	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 ____/____/____

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 4W321
Des Moines, IA 50306-9232
or email to:
wellmarkecsolutionsregistration@hp.com

PROVIDER AUTHORIZATION FOR ELECTRONIC TRANSACTIONS VIA THIRD PARTY

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

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

authorize Claims Processing Service dba Emdeon Business Services,
(Clearing House/Billing Service)

submitter number 704 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
PO BOX 9232, Mail Station 4W321
Des Moines, IA 50306-9232
or email to:
wellmarkecsolutionsregistration@hp.com

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:
EC Solutions
Attention: EC Registration Department
PO BOX 9232, Mail Station 4W321
Des Moines, IA 50306-9232
or email to:
wellmarkecsolutionsregistration@hp.com