



Capario Enrollment
1901 E. Alton Ave. #100
Santa Ana, CA. 92705
Phone: (800) 792-5256 Option 1
Fax: (404) 877- 3324
provider.enrollment@Capario.com

ERA Payer Agreement Instructions for WPS Commercial Insurance (WPS01)

You will enroll for ERAs by completing and sending the Payer Agreement directly to the Payer. In addition please complete and send the Capario ERA Enrollment Request Form to our EDI Team. Specific instructions for this Payer are shown below.

ERA Transactions are available as an additional Capario contracted service. To add ERAs to your contract please contact your Capario Sales person or Account Manager. ERAs must be part of your contract and you must be enrolled with this Payer BEFORE submitting this ERA Payer Agreement.

EFT enrollment and transmission is an arrangement between the provider and the Payer. If the Payer offers EFT transactions contact them to determine if they:

- Require you to receive EFTs in order to receive their ERAs
- Charge an additional fee for EFTs/ERAs
- Require you to enroll for EFTs on this ERA enrollment form.

Guidelines for Enrolling with this Payer

1. Fax or mail the completed **WPS Commercial Provider Authorization for WPS Electronic Remittance Advice** to:

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
Madison, WI 53708-8128
Fax: (608) 223-3824

2. Fax or mail the **Capario ERA Enrollment Request Form** to:

Fax: (404) 877-3324
EDI Team
Capario
1901 E. Alton Ave. Suite 100
Santa Ana, CA. 92705

To obtain the Capario ERA Enrollment Request Form, go to:
www.capario.com/services/resource_center/enrollment_instructions.html

Questions? Contact Capario Enrollment at: (800) 792-5256 Option 1



08/10/10

WPS COMMERCIAL PROVIDER AUTHORIZATION FOR WPS ELECTRONIC REMITTANCE ADVICE

Due to privacy regulations, this request must be submitted by the provider's office or authorized billing agent.

***Check all lines of business that apply:**

WPS Commercial _____ MCDFC _____ CCCW _____ CLTS _____ HIRSP _____

Southwest Family Care Alliance _____

***NOTE** - TRICARE providers should use the appropriate TRICARE ERA request form.

The only version of electronic remittance available is 4010A1.

ERA PROVIDER INFORMATION

***PROVIDER/FACILITY NAME:** _____

***PROVIDER/FACILITY TAX ID:**

List below NPI's and correlating physical location requesting an electronic remittance advice (**attach additional sheet if necessary.**)

<u>GROUP NPI</u>	<u>*PHYSICAL LOCATION</u>	<u>*PAYMENT LOCATION</u>
1. _____	_____ _____ _____	_____ _____ _____
2. _____	_____ _____ _____	_____ _____ _____
3. _____	_____ _____ _____	_____ _____ _____
4. _____	_____ _____ _____	_____ _____ _____

If you add an additional service location in the future and wish to receive ERA for this new location, go to our EDI web site at http://www.wpsic.com/edi/pdf/edi_ern_wps.pdf download another form.

***REQUIRED**

ERA REQUESTER INFORMATION

*Requesters Contact Name: _____

*Requesters Phone #/Email Address: _____

***Print Provider Authorized Name:** _____

***Authorized Signature:** _____ ***Date:** _____

EDI CLAIM INFORMATION

Who submits your EDI claims? Submitter #: _____

Who will be receiving your ERAs?

*Electronic Claim Payment/Advice Receiver # _____

If you don't use a Clearinghouse and receive your ERA's directly, what is your Receiver ID: _____

If you wish to receive ERA's (ANSI 835 file) direct to your office. *if you haven't already*, please register for a trading partner/ERA receiver number at: <https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do>. Place 5 digit assigned trading partner number in the field: _____

If you don't know your Clearinghouse Receiver ID, contact your Clearinghouse.

*Billing Service/Clearinghouse Name: _____

Contact Name: _____

Contact Phone#: _____

Contact Email address: _____

Date to begin ERA: _____

Due to HIPAA requirements, only one submitter ID per provider number may be established for ERA. The submitter ID on this request will be the only recipient of ERA for the provider(s) listed.

An original or faxed copy will be accepted. Please mail or fax your completed agreement to:

Wisconsin Physicians Service
Electronic Data Service
P.O. Box 8128
Madison, WI 53708-8128
Fax (608-) 223-3824

***REQUIRED**



Dear WPS Provider:

Reminders: Complete and return all 3 pages

Thank you for choosing the electronic method for submission of your healthcare claims. Wisconsin Physicians Service requires that all new electronic providers/groups sign, and have on file, a "Provider Agreement to Submit Electronic Media Claims" prior to submitting electronic claims. We request that you complete and return this agreement form, including this cover letter, to our office.

An organization that has several providers can execute a single Provider Agreement form on behalf of the group. Only one authorizing individual is needed to sign the agreement for the Clinic/Group. (Note: A separate agreement is required for each Tax ID.)

In addition to the agreement, the following information is needed (please print):

Clinic Tax ID:	Clinic NPI Number(s):
Physician/Clinic/Institution Name:	
Address:	
City/State/Zip:	Billing Service/Clearinghouse (if applicable):
Contact Name:	Phone Number:
Contact e-mail address:	Fax Number:
Provider/clinic/institution physical location(s) address:	
NOTE: If you have multiple physical locations, please attach a list including the associated billing and NPI address for each	

Please indicate your EDI submission option:

- Name of Billing Service/Clearinghouse (if applicable):** _____
- Direct Filing via WPS Bulletin Board System or Internet Batch** (using vendor supplied EDI software program and transmitting from your site) **Name of Vendor if Billing direct (if applicable):** _____
 - If this option is selected, please register as a submitter through the WPS Trade Partner System (WTPS) at <https://corp-ws.wpsic.com/apps/wtps-web/unauth/wtps.do>.
 - If you have already registered as a submitter, please provide the submitter number assigned _____.
 - If you need assistance with registration, please contact WPS Electronic Data Services at 800-782-2680, option 4.
- PC-Ace software – Free claims submission software supplied by WPS**

Please indicate your method of transmission if sending Direct:

_____ **WPS-batch Internet claim submission** _____ **WPS Bulletin Board System**

*Please note: A faxed, e-mailed faxed image or original will be accepted. Please mail, fax or e-mail your completed agreement to:

WPS Electronic Data Services
WPS Insurance Corporation
P.O. Box 8128
Madison, WI 53708-8128
Fax (608) 223-3824
E-Mail Address: edi@wpsic.com

Note: If you are a new provider/location or have recently changed your physical or billing address, it is important that WPS update our provider file before you submit your EDI Provider Agreement. Please contact WPS/EPIC Member Services at 1-800-765-4977 for in-state providers or 1-800-356-8051 for out-of-state providers. You can also fax your updated information to 608-221-6161.

For Office Use Only

BL(s) _____, _____, _____, _____

Sub # _____ CH _____ Direct _____ CTY _____

EACV: _____ WC _____ G _____ M _____ C _____ S _____

ALS _____ App Dt _____ Marketer Initials _____

Orig Sub # _____ New Sub # _____ Memo _____ ERAU _____ Initials _____

AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER (EFT)

WPS Commercial providers must be submitting electronically and be receiving Electronic Remittance Advise (ERA) in order to receive Electronic Funds Transfer (EFT).

***Note: This does not include WPS Commercial Family Care Programs.**

Please complete the attached form to enroll for Electronic Funds Transfer for WPS Commercial.

Return completed forms, with original signatures, to:

**Wisconsin Physicians Service
Electronic Data Service
P.O. Box 8128
1717 W. Broadway
Madison, WI 53708-8128**

INSTRUCTIONS FOR COMPLETING THE EFT AUTHORIZATION AGREEMENT

All EFT requests are subject to a 15-day pre-certification period in which all accounts are verified by the qualifying financial institution before any TRICARE direct deposits are made.

PART I – REASON FOR SUBMISSION

Indicate if this is a new EFT authorization or change to your existing account information. If you are authorizing EFT payments to the home office of a chain organization of which you are a member, you must attach a letter authorizing the contractor to make payment due the provider of service to the account maintained by the home office of the chain organization. The letter must be signed by an authorized official of the provider of service and an authorized official of the chain home office.

PART II – IDENTIFICATION DATA

Line 1 – Enter the name of the physician or individual practitioner or the legal business name of the provider/supplier as reported to the Internal Revenue Service (IRS). The account must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.

Line 2 – Enter the provider's/supplier's legal business name. The account to which EFT payments made must be solely in the name of the physician or individual practitioner or in the legal business name of the person or entity.

Line 3 – Enter the chain organization's name.

Line 4 – Enter the home office legal business name if different from the chain organization name.

Line 5 – Enter the tax identification number as reported to the IRS. If the business is a corporation, provide the Federal employer identification number, otherwise provide your Social Security Number.

Line 6 – If issued, enter the Medicare identification number assigned by a Medicare fee-for-service contractor. If you are not enrolled in Medicare, leave this field blank.

Line 7 – Enter the 10 digit NPI number. The NPI is required to process this form.

PART III – DEPOSITORY INFORMATION (Financial Institution)

Line 8 – Enter your depository name (this is the name of the bank or qualifying financial institution that will receive the funds).

Line 9 – Enter the account holder's name.

Line 10 – Enter the account holder's street address.

Line 11 – Enter the account holder's city, state and ZIP code.

Line 12 – Enter the bank or financial institutional telephone number.

Line 13 – Enter the bank or financial institutional nine-digit routing number.

Line 14 – Enter the depositor's account number and select the account type.

If you do not submit this information, your EFT authorization agreement will be returned without further processing.

PART IV – CONTACT PERSON

Enter the information for the contact person responsible for this EFT authorization agreement.

PART V – AUTHORIZATION

Line 21 – By your signature on this form you are certifying that the account is drawn in the name of the physician or individual practitioner or in the legal business name of the provider or supplier. The provider or supplier has sole control of the account to which EFT deposits are made in accordance with all applicable regulations and instructions. Arrangements between the depository and the provider or supplier are in

accordance with applicable regulations and instructions with the effective date of the EFT authorization. You must notify WPS regarding any changes in the account in sufficient time to allow WPS and the depository to act on changes. The EFT authorization form must be signed and dated by the same Authorized Representative. Mail this form with the original signature (no facsimile signatures can be accepted) to WPS.

WPS COMMERCIAL ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION AGREEMENT

PART I – REASON FOR SUBMISSION

- Reason for Submission: New EFT Authorization
- Revision to Current Authorization (e.g. account or bank changes)
- Chain Home Office: Check here if EFT payment is being made to the Home Office of Chain Organization (Attach letter Authorizing EFT payment to Chain Home Office)
- EFT Termination Request

PART II – PROVIDER OR SUPPLIER INFORMATION

Name _____

Provider/Supplier Legal Business Name _____

Chain Organization Name _____

Home Office Legal Business Name
(if different from Chain Organization Name) _____

Tax Identification Number _____

National Provider Identifier (NPI) _____

List all physical & billing locations requesting EFT. Attach additional sheet if necessary. Street/City/State/Zip Code

Physical Address	Provider Payment Address
1.	
2.	
3.	
4.	

PART III – DEPOSITORY INFORMATION (Financial Institution)

Depository Name _____

Account Holder's Name _____

Account Holder's Address:
Street _____

City _____ State _____ Zip _____

Depository Telephone Number _____

Depository Contact Person _____

Depository Routing Transit Number (nine digit) _____

Depository Account Number _____

Type of Account (check one) Checking Account Savings Account Lock Box

Please include a **voided check**. When submitting the documentation, it should contain the name on the account, electronic routing transit number, account number and type, and, if

the information is provided on **bank letterhead**, a bank officer's signature. This information will be used to verify your account number.

PART IV – CONTACT PERSON

First Name

Middle Initial

Last Name

Telephone Number

Fax Number (if applicable)

Address Line 1 (Street Name and Number)

Address Line 2 (Suite, Room, etc.)

City/Town

State

Zip

E-mail Address

PART V – AUTHORIZATION

Authorization

I hereby authorize WPS, hereinafter called the COMPANY, to initiate credit entries, and in accordance with 31 CFR 210.6(f) initiate adjustments for any credit entries made in error (does not include program overpayments) to the account indicated above. I hereby authorize the financial institution/bank named above, hereinafter called the DEPOSITORY, to credit and/or debit the same to such account.

If the account is drawn in the Physician's or Individual Practitioner's Name, or the Legal Business Name of the Provider/Supplier, the said Physician/Provider/Supplier certifies that t he/she has sole control of the account referenced above, and certifies that all arrangements between the DEPOSITORY and the said Physician/Provider/Supplier are in accordance with all applicable WPS regulations and instruction.

This authorization agreement is effective as of the signature date below and is to remain in full force and effect until the COMPANY has received written notification from me of its termination in such time and such manner to afford the COMPANY and the DEPOSITORY a reasonable opportunity to act on it. The COMPANY will continue to send the direct deposit to the DEPOSITORY indicated above until notified by me that I wish to change the DEPOSITORY receiving the direct deposit. If my DEOSITORY information changes, I agree to submit to the COMPANY and updated EFT Authorization Agreement.

Signature Line

Authorized/Delegated Official Name (Print)

Authorized/Delegated Official Title

Authorized/Delegated Official Signature

Date

Return completed form with original signatures to:

Wisconsin Physicians Service
Electronic Data Services
P.O. Box 8128
1717 W. Broadway
Madison, WI 53708-8128