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

Payer Agreement Instructions for New Jersey Blue Cross Blue Shield (BS031)

To enroll with this payer complete and send the payer agreement directly to Emdeon. In addition please complete and send the Capario Provider Enrollment Form to our EDI Team. Specific instructions for this Payer are shown below.

If you are a Capario customer then complete the Payer enrollment process BEFORE submitting claims to Capario for this Payer.

If you are not yet a Capario customer please contact Capario sales at: ProviderSales@Capario.com or 800-586-6870.

Guidelines for Enrolling with this Payer

1. **Fax or Mail the Payer Forms to:**
   Emdeon Business Services
   Donelson Corporate Ctr Bldg 3
   3055 Lebanon Pike Ste 2000
   Nashville, TN 37214
   Fax: (615) 231-4843

2. **Fax or Mail the Capario Provider Enrollment Form to:**
   Fax: (404) 877-3324
   EDI Team
   Capario
   1901 E. Alton Ave. Suite 100
   Santa Ana, CA. 92705

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

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

Emdeon Claims Provider Setup Form

Email: batchenrollment@emdeon.com
Fax: (615) 885-3713

1 Provider Organization

Practice/Facility Name		Billing NPI	
Provider Name			
Provider Specialty Code		Tax ID		Site ID	
Practice/Facility Provider Address	Street		
	City		State		Zip Code	
Contact Name		Contact Phone Number	

2 Vendor (Emdeon Certified Vendor used to submit files to Emdeon)

Vendor Name			
Vendor Submitter ID			
Contact Name		Contact Phone Number	

3 Report Method

TSO ID		Communication Protocol/Output	
Report Type		Report Format	

4 Payer

M = Medical	☐	H = Hospital	☐

Please list additional payers below
Check the Emdeon Payer List to see if additional enrollment is required at: http://www.emdeon.com/PayerLists/payerlists.php

Payer ID	Group ID	Individual ID	NPI ID	Payer ID	Group ID	Individual ID	NPI ID

5 Confirmations (Enter E-mail address)

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Section 1 Provider Organization section must be fully completed with Facility/Provider information, failure to complete all fields may result in form rejections. Do not list Vendor or Billing Service information. Billing NPI is required to complete enrollment.

Revised 01/19/2010

PAYER ID: 22099 SUBMITTER ID:

Emdeon Claims Provider Information Form

*This form is to ensure accuracy in updating the appropriate account

1 Provider Organization

Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	

2 Vendor *(Emdeon certified vendor used to submit files to Emdeon)*

Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					

3 Payer

Payer ID	22099 NEW JERSEY BCBS	
Group ID	Individual Provider ID	NPI ID

4 Confirmations

Send Emdeon Claim Confirmations To:	

Special Instructions:

- **All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.**
- **SUBMIT COMPLETED FORM TO:**

  Fax: (615) 231-4843

  Email: batchenrollment@Emdeon.com

EMDEON REVISION FORM DATE: 04/08/08

Horizon Blue Cross Blue Shield of New Jersey

Horizon Blue Cross Blue Shield of New Jersey
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)______________________ NPI Number ______________________
(Required for Multispecialty Groups with assigned suffix)

Mode of Transmission:

Please check only one.

Specific to:	Rules and Regulations
☐ **HorizonNet 2000** **Or** ☐ ***Software Vendor**	In the case that we use HorizonNet 2000, we agree to authorize Horizon Blue Cross Blue Shield of New Jersey (Horizon BCBSNJ) 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.
☒ ***Clearinghouse** **Or** ☐ ***Billing Service**	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.
☐ **Hospital, Facility, Physician or Other Health Care Professional Programming Horizon BCBSNJ Specification**	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: EMDEON

3193 EDI (W0407)

An independent licensee of the Blue Cross and Blue Shield Association.

Electronic Transactions Available:

Please check the electronic transactions that you are applying for:

Claims: ☒ **Physician or other Health Care Professional** **Or** ☐ **Hospital or Facility**	We agree that the information on claims submitted electronically will be true, accurate and complete; and agree to keep such records as are necessary to disclose fully the extent of services and allow Horizon BCBSNJ reasonable access to all source documents and medical records related to any claim. We accept the liability for all claims submitted to Horizon BCBSNJ and will promptly refund any overpayment made by Horizon BCBSNJ on electronic claims. We realize that anyone who falsifies electronic claims information may, on conviction, be subject to fines and/or imprisonment under Federal Law. We agree that it is our responsibility to reconcile claim response reports / messages received from Horizon BCBSNJ, including acknowledgement of claim receipt from Horizon BCBSNJ, to assure our claims were received by Horizon BCBSNJ.
☐ **Requests for Authorization (Req Auth)**	We agree that any and all Req Auths sent electronically contain true, accurate and complete information. We agree that it is our responsibility to assure that Horizon BCBSNJ has received our Req Auths by reconciling response reports returned to us.
☐ **Eligibility**	We realize that the eligibility information returned by Horizon BCBSNJ is contingent on the information available at the moment of transmission. We understand that eligibility for a particular patient may change between the time of inquiry and the time the claim is processed. Payment determinations will be made based on eligibility at the time that services are provided.
☐ **Referrals**	We agree that any and all information contained on our electronic referrals is based on medical necessity. We understand that acceptance of this referral does not guarantee payment. We understand that payments are determined based on contracts and contract limitations. We agree that it is our responsibility to assure that Horizon BCBSNJ has received our referrals by reconciling response reports returned to us.
☐ **Payment Advice**	We realize that the payment advice information returned by Horizon BCBSNJ is contingent on the information available at the moment of transmission. Payment determinations will be made based on eligibility at the time that services are provided, and may be subject to change.
☐ **Premium Payment**	We realize that this transaction is used for the purpose of reporting payroll deducted and other group premiums for all users sending premium payments to Horizon BCBSNJ. We agree that it is our responsibility to ensure funds are available to cover premiums.
☐ **Benefit Enrollment**	We agree that the information submitted electronically will be true, accurate and complete. We realize this transaction is used only to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to Horizon BCBSNJ. We accept the liability for all files submitted to Horizon BCBSNJ.

Signature ____________________ Title ____________________

Print / Type Name ____________________ Date ____________________

Mail Completed Form to:

EDI Services PP-11C
Horizon Blue Cross Blue Shield of NJ
3 Penn Plaza East
Newark, NJ 07105-2200
Fax: 1-973-274-4353