



**Electronic Data Interchange (EDI)
Provider Enrollment Form**

SECTION I: Provider Information

Practice/ Facility Name:		NPI Type II: (required)
Primary Physical Address:	Remittance Address:	
County:		
Contact Person:		
Practice/Facility EDI Contact Person e-mail address: (required)		
Practice/Facility Telephone #:	Practice/Facility Tax ID#:	
Type of Practice (indicate with an X): Group: <input type="checkbox"/> Solo: <input type="checkbox"/> N/A: <input type="checkbox"/>		

SECTION II: Requesting the following ASC X12 HIPAA transactions
(place an "X" in each applicable box)

837 I (Claim: Institutional) <input type="checkbox"/>	276/277 (Claim Status Request and Response) <input type="checkbox"/> (BATCH PROCESS ONLY)
837 P (Claim: Professional) <input type="checkbox"/>	278 (Services Review-Request for Review and Response) <input type="checkbox"/> (BATCH PROCESS ONLY)
270/271 (Eligibility/Benefit Inquiry and Response) <input type="checkbox"/> (BATCH PROCESS ONLY)	

SECTION III: EDI Software Vendor/Billing Company/EDI Clearinghouse/Practice Management System Information

Name of EDI Clearinghouse that will be Submitting Claims to Geisinger Health Plan (must check one) <input type="checkbox"/> Emdeon <input type="checkbox"/> RelayHealth	
Name of Intermediate EDI Clearinghouse (if applicable):	Telephone #:
Name of EDI Software Vendor (if applicable):	Telephone #:
Name of Billing Company (if applicable):	Telephone #:
Name of Practice Management System (if applicable):	Telephone #:
Provider EDI Contact Person:	Telephone #:



SECTION IV: Provider/Facility Enrollment

(Within your organization or practice, please list each entity or provider permitted to submit claims under the Tax ID# as listed in Section I. If more than 6 entries are made, please make a copy of this form to complete the remaining entries.)

Providers submitting UB04 claim forms:	Providers submitting CMS1500 claim forms:
<u>Provider/Facility Name:</u>	<u>Provider Name & Credentials</u> (if applicable):
<u>NPI Type II:</u> (required)	<u>NPI Type I:</u> (required)
<u>Provider/Facility Name:</u>	<u>Provider Name & Credentials</u> (if applicable):
<u>NPI Type II:</u> (required)	<u>NPI Type I:</u> (required)
<u>Provider/Facility Name:</u>	<u>Provider Name & Credentials</u> (if applicable):
<u>NPI Type II:</u> (required)	<u>NPI Type I:</u> (required)
<u>Provider/Facility Name:</u>	<u>Provider Name & Credentials</u> (if applicable):
<u>NPI Type II:</u> (required)	<u>NPI Type I:</u> (required)
<u>Provider/Facility Name:</u>	<u>Provider Name & Credentials</u> (if applicable):
<u>NPI Type II:</u> (required)	<u>NPI Type I:</u> (required)
<u>Provider/Facility Name:</u>	<u>Provider Name & Credentials</u> (if applicable):
<u>NPI Type II:</u> (required)	<u>NPI Type I:</u> (required)
<u>Provider/Facility Name:</u>	<u>Provider Name & Credentials</u> (if applicable):
<u>NPI Type II:</u> (required)	<u>NPI Type I:</u> (required)
<u>Provider/Facility Name:</u>	<u>Provider Name & Credentials</u> (if applicable):

Geisinger Health Plan, Geisinger Indemnity Insurance Company, and Geisinger Quality Options, Inc. (herein referred to as "Health Plan")

Attestation: Geisinger Health Plan (EDI) Provider Enrollment Form

I hereby apply to the Health Plan for the purpose of electronic exchange of data including, but not limited to, the minimum necessary protected health information (as defined under the Health Insurance Portability Accountability Act of 1996) between the Health Plan and myself, or my authorized agent related to electronic data exchange transactions. Upon processing by the Health Plan, the information on this form shall be [activated] and the parties hereunder may begin the electronic exchange of such data through a Certified Software Vendor. I, or my authorized agent, agree to notify the Health Plan within five (5) business days of learning of any change to the information contained within this application. Either the Health Plan or I may terminate the electronic exchange of data at any time, upon prior notification to the non-terminating party. The information contained within this application is true, correct and complete in all respects to the best of my knowledge and belief. I understand that the misrepresentation of any material fact by me on this application could constitute grounds for termination of the transmission, receipt or otherwise access of electronic exchange of data between the parties.

Signature of Provider/Facility [Applicant]

Date