Instructions for Completing Wellmark BCBS Electronic Transaction Registration Form

1. Per the payer, the Practice Management Software section is optional
2. Complete the Provider Information section.
    - PO boxes not accepted
3. List the Tax ID and NPI information
4. Email (preferred) the completed form(s) to csenrollment@experianhealth.com or fax to 866.921.8415, attention CSEnrollment. Please include the attached cover sheet.

Third Party Agencies: Please have your client(s) follow the steps outlined above and return the completed forms to you to return to Experian.

Thank you for your interest in Experian!

Payer Enrollment Cover Sheet

To process your payer enrollment correctly, please complete the below before sending in the form.

- Client ID:
- Partner Name (if applicable):
- Facility Name:
- Contact Name:
- Contact Email:
- Contact Phone #:

If you have any questions please email **CSenrollment@experianhealth.com**

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: Passport Health Communications

Contact: Passport Enrollment Team Title: Enrollment

Phone: (866) 854-6796 Fax: (866) 921-8415

Submitter Address 1: 720 Cool Springs Blvd.Suite 200

Submitter Address 2:

City: Franklin State: TN Zip Code: 37067

County: Williamson Email Address: enrollment@passporthealth.com

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

If yes, what is your Submitter ID? RTE11324

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	**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 ____/____/____