



Payor Agreement Cover Sheet

Agreement Type: Claims

CPID: _____ Payor Name: _____

Submitter ID: _____

Submitter Name: _____

Customer ID: _____

Billing ID: _____

Customer Contact: _____

E-mail: _____

Return completed agreement to:

McKesson
Attn: Enrollment Dept. (IADU6)
700 Locust Street
Dubuque, IA 52001



This section for McKesson Internal Use:

Notes: _____

HIP Health Plan of New York EDI Information Sheet

Section A: To be completed by PC, Physician or Billing Manager. Upon completion, please fax to HIP EDI Team (646-447-3185). Please do not submit claims electronically to HIP until you are advised by the HIP EDI Team to proceed. All fields are required.

Pay to Name:	
Tax ID:	
Billing Address	
Servicing Address:	
Telephone Number:	
Fax Number:	

Affiliated Physician Roster: (List Physician's Last Name, First Name, NY State Physician License Number). Note: If extra space is required, please attach a separate sheet of paper to this form.

Last Name	First Name	License Number

Physician Office/Contact Name: _____

Email Address: _____

Practice Management Software: _____

Note: HIP will process claims according to the servicing locations fee schedule based upon the contractual agreement between HIP and the Provider. If you would like to discuss which option is best for your Practice Management System, please call HIP at 1-800-447-8386.

Please read and sign the following acknowledgement:

I agree that any claims submitted to HIP EDI format shall comply with security and privacy requirements applicable to individually identifiable financial and health information as set forth in (i) the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, as amended from time to time ("HIPAA"); and (ii) Title 11 NYCRR Section 420, as may amended from time to time ("New York State Insurance Regulation 169").

Acknowledge and Agreed :

By: _____

Its: _____

Date: _____