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: ____

____

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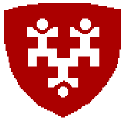
Revised on 09/22/03



Harvard Pilgrim
Health Care

EDI Authorization Form

Print Name of Physician or Group: ____

Practice Address: ____

Billing Address/Pay to: ____

Office Contact Person: ____

Telephone #______________________Fax #______________________E-Mail__________________________

Harvard Pilgrim Provider #_______________ Provider Tax Id #__________________Specialty_____________

A separate authorization form is not necessary for other providers in your group practice. Please attach a complete list of their names and provider numbers.

If using outside billing service specify:

Name: ____

Contact: ______________________________________Telephone#___________________________________

Software Vendor Name: __________________________ EDI/IT Contact Person__________________________

Expected Date of First Electronic Submission:____

Signature waiver:

This authorization is intended to ensure a consistent approach throughout the organization with respect to the maintenance, access, use and disclosure of Provider information and to protect the privacy of Member Information in all settings. I acknowledge and undertake full personal responsibility for all claims submitted to Harvard Pilgrim Health Care as I have personally signed each HPHC Claim Form.

____ Date: ____________________________________

Signature of physician or authorized representative

Type or print name: ________________________________ Title: _____________________________________

Please indicate submission method:

O **WEBMD** O **ProxyMed/MedUnite** O **Direct 837 (Version 4010A1)**

PLEASE RETURN TO:
THE EDI TEAM
HARVARD PILGRIM HEALTH CARE
1600 CROWN COLONY DRIVE- 2S
QUINCY, MA 02169
Fax # 617-509-1165
E-mail address: EDI_team@hphc.org