



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: _____

MCKESSON

HEALTH PARTNERS CPID #3411

ALTHOUGH NO AGREEMENT IS REQUIRED, THE PAYOR HAS REQUESTED THE FOLLOWING INFORMATION:

NAME OF GROUP: _____

CONTACT PERSON: _____

PHONE NUMBER: _____

ADDRESS: _____

E-MAIL ADDRESS OF CONTACT PERSON: _____

PLEASE CHECK ONE: ELECTRONIC CLAIMS _____ REMITTANCE _____

IF REMITTANCE, PLEASE SELECT ONE BELOW:
DO YOU WANT TO RECEIVE ELECTRONIC REMIT **OR** ELECTRONIC REMIT & PAPER

PLEASE SELECT ONE:
IS YOUR PRACTICE FILING AS A _____ GROUP OR _____ INDIVIDUALLY?

GROUP/INDIVIDUAL PROVIDER NUMBER (HPFIN #): _____

TAX ID #: _____