

New Billing Service Form

COMPLETE ONE FORM FOR EACH OFFICE LOCATION & EACH PROVIDER

ICS will complete the paperwork then fax/mail the completed forms to you, the provider. You will then send the forms to the carrier.
Instructions will be attached to the forms. When the submitter numbers are obtained please fax them to ICS to complete the setting sheets.

Which Program did you purchase? <input type="checkbox"/> Sammy USA <input type="checkbox"/> Simple Sam Plus <input type="checkbox"/> Simple Sam		
Name of Billing Service _____		
How did you hear about Sammy? <input type="checkbox"/> Current customer _____ <input type="checkbox"/> Website <input type="checkbox"/> Advertisement		
<u>PROVIDER NAME</u>	<u>Service Address</u> (CMS 1500 Box 32)	<u>Service City, State Zip + 4</u>
	<u>Pay to Address</u> (CMS 1500 Box 33 if different)	<u>Pay to City, State Zip + 4</u>
Telephone: _____ Fax: _____ Email: _____		
Individual NPI: _____ Tax ID: - OR SS: - -		
<u>GROUP NAME</u>	<u>Pay to Address</u> (CMS 1500 Box 33 if different)	<u>Pay to City, State Zip + 4</u>
Telephone: _____ Fax: _____ Email: _____		
Organizational NPI: _____ Tax ID: -		

Complete ONLY what you would like to ADD/CHANGE/REMOVE
If you are a group you **MUST** fill out both individual information and group information!

Medicare (You **MUST** provide EOB or CMS enrollment letter)
Carrier Name _____ Ind Provider #/PTAN _____ Group Provider#/PTAN _____

BCBS
Carrier Name _____ (If your carrier is Empire BCBS fill out only individual information)
Individual Provider # _____ Group Provider# _____

Railroad Medicare (You **MUST** provide EOB or CMS enrollment letter)
Individual Provider # _____ Group Provider# _____

DMERC/CEDI (You **MUST** provide EOB or CMS enrollment letter)
SS# _____ - _____ - _____ Tax ID #* _____ - _____ Provider # _____
*If billing DMERC under a Tax ID, you **MUST** include an Organizational NPI at the top of this form

Medicaid
State _____ If you answered "NY", do you have an EPACES account? Yes No
Individual Provider # _____ Group Provider# _____

CDPHP (Capital District Physician's Health Plan)
Individual Provider # _____ Group Provider# _____

NEIC/ZIP Commercial Claims Internal office use: TSO _____ Site ID _____
Provider Specialty _____

I permit ICS Software, Ltd. its employees and agents, to obtain the necessary electronic logons/passwords/submitter numbers so my office can transact electronic EDI services with the insurance company. The insurance company should take this as authorization to release the electronic information to ICS Software, Ltd. **Please note: You will be sent an invoice for \$50 upon receipt of this form by ICS. If you opt not to provide ICS with EOB s as requested and/or incorrect provider numbers, additional charges will apply.**

Signature: _____ Date: _____ Fax to: **516-763-1017**