ICS Software, Ltd
The Sammy Systems

Phone: 516-766-2129 Fax: 516-763-1017
E-mail: Support@ICSSoftware.net

Existing Customer

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.

Is this a new doctor in your practice who is not yet in Sammy? __Yes __No

PROVIDER NAME	**Service Address** *(CMS 1500 Box 32)*	**Service City, State Zip + 4**
	Pay to Address *(CMS 1500 Box 33 if different)*	**Pay to City, State Zip + 4**
Telephone:	**Fax:**	**Email:**
Individual NPI:	**Tax ID:** -	**OR SS:** - -
GROUP NAME	**Pay to Address** *(CMS 1500 Box 33 if different)*	**Pay to City, State Zip + 4**
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 __Add __Remove __ERA ***(You MUST provide EOB or CMS enrollment letter)***
Carrier Name _______________ Ind Provider #/PTAN _______________ Group Provider#/PTAN_______________

BCBS __Add __Remove __ERA
Carrier Name _______________ *(If your carrier is Empire BCBS fill out only individual information)*
Individual Provider #__________________ Group Provider# __________________

Railroad Medicare __Add __Remove __ERA ***(You MUST provide EOB or CMS enrollment letter)***
Individual Provider #__________________________ Group Provider# __________________

DMERC/CEDI __Add __Remove __ERA ***(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 __Add __Remove __ERA
State _______ If you answered "NY", do you have an EPACES account? __Yes __No
Individual Provider #_______________ Group Provider# __________________

CDPHP (Capital District Physician's Health Plan) __Add __Remove __ERA
Individual Provider #_______________ Group Provider# __________________

NEIC/ZIP Commercial Claims __Add __Remove *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**