

**New 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.

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

**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 (You MUST provide EOB or enrollment letter)**

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