|  |
| --- |
| Picture |

# Electronic Claims Submission Request Form

## Instructions

* **ALL FIELDS ARE REQUIRED**
* Form must be filled out and signed by an authorized representative for the provider
* Please email all completed forms to HSMSOEDI@HealthsourceMSO.com
* Once the provider has been approved, HSMSO will email the contacts below with instructions on how to submit electronic claims to HSMSO

## Vendor Information

|  |  |
| --- | --- |
| **Provider Name:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Provider Tax ID:** |  |  Provider NPI: |  |

|  |  |
| --- | --- |
| **Which IPA/Hospital is the Provider Contracted With:** |  |

|  |
| --- |
|  |

## Authorized Representative Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Title:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Phone Number:** |  |  Email: |  |

## EDI/Technical Contact Information

|  |  |  |  |
| --- | --- | --- | --- |
| **Name:** |  | **Title:** |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Phone Number:** |  |  Email: |  |

## Claim Submission Information

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Claim Submission Type? | UB04[ ]  | CMS 1500[ ]  | Will This Provider Submit Attachments? | YES[ ]  | NO[ ]  |

|  |  |  |  |
| --- | --- | --- | --- |
| Authorized Signature: |  | Date: |  |