



**ezConnect Electronic Encounter/Claims Submission
Provider Application**

Section 1: Provider Information		
Provider Name	Provider NPI:	Group NPI:
Service Address	Mailing Address	
City, State, Zip	City, State, Zip	
Contact Name	Telephone/FAX Numbers	Email Address
9 Digit Federal Tax ID Number	State License Number <i>(attach list if more than one provider)</i>	

Section 2: Data Specifications Information		
Which data standard do you plan to use to submit encounters/claims?		
NSF 2.0 _____ UB92 4.0/5.0 _____ ANSI 837 <input checked="" type="checkbox"/> Version # _____ Unknown _____ <i>If you plan to use NSF 2.0, please provide your NSF 2.0 Submitter ID: _____</i>		
Line of Business	Professional (HCFA 1500) Estimated Monthly Volume	Institutional (UB 92) Estimated Monthly Volume
Alta Bates Medical Group		
Central Valley Medical Group		
Santa Rosa Network		
Sutter Delta Medical Group		
Sutter East Bay Medical Foundation		
Sutter Gould Medical Group		
Sutter Independent Physicians		
Sutter Medical Group		
Sutter Regional Medical Foundation		
Sutter Select		
Sutter Senior Care		
Sutter West Medical Group		
Yolo Health Alliance		

Section 3: Submitter Information

Please provide the following *(if applicable)*:

Practice Management Company Name	Billing Service Name
Clearinghouse Name Office Ally	
<i>If none, may we forward this information to a clearinghouse?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <i>Signature</i> _____	
Contact Name/Number	Other (please explain)
Your Company Name <i>(if different than Section 1)</i> :	
Your Address:	
City, State, Zip Code (9 digit)	
Contact Person:	Telephone/FAX Numbers
	Email Address

PLEASE RETURN COMPLETED FORM TO:

Sutter Connect, IT/EDI Dept.
P.O. Box 254707
Sacramento, CA. 95865-4707
Or Fax (916) 854-6722

For additional information or for assistance in completing the application, call 1-800-611-5191

NOTE TO MY CLIENTS PLUS USERS:

Once you have confirmed with the insurance payor that your provider number is linked to Office Ally, please fax the following information to My Clients Plus at 888-653-7115.

- **My Clients Plus**
- **Provider/Practice Name as pre-enrolled with the insurance payer**
- **Fed Tax ID**
- **Billing NPI**
- **Insurance Payer (including State if BCBS, Medicare or Medicaid).**
- **The statement “I have verified my provider ID has been linked to Office Ally with the Insurance Payor”.**
- **Provider email address where you can be notified of setup completion.**

For Noridian Pre-Enrollments Please Also Include:

- **Submitter number**