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 *(attach list if necessary)*	

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 _XXX_ Version # __________ Unknown __________

If you plan to use NSF 2.0, please provide your NSF 2.0 Submitter ID:____________________________

Line of Business	Professional (HCFA 1500) Estimated Monthly Volume	Institutional (UB 92) Estimated Monthly Volume
Alta Bates		
Santa Rosa		
Sutter Delta Medical Group		
Sutter East Bay Medical Foundation		
Sutter Gould		
Sutter Independent Physicians		
Sutter Medical Group		
Sutter Regional Medical Foundation		
Sutter West Medical Group		
Yolo Health Alliance		

Medium used for electronic claims submission: *(please select one)*

Internet FTP _XXX_	CD ROM	Diskette	DAT Tape	Other:

Section 3: Submitter Information

Please provide the following *(if applicable)*:

Practice Management Company Name	Billing Service Name
Clearinghouse Name Office Ally *If none, may we forward this information to a clearinghouse? ______ Yes ______ No Signature* ____________________________________	
Contact Name/Number	Other (please explain)
Your Company Name *(if different than Section 1)*:	
Your Address:	
City, State, Zip Code (9 digit)	

Contact Person:	Telephone/FAX Numbers	Email Address

PLEASE RETURN COMPLETED ORIGINAL TO:

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

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