

ELECTRONIC SUBMISSION APPLICATION: North & South Carolina

Complete the accompanying EDI Form and submit to HealthSpring at fax number located below.
Our EDI Coordinator will contact individual identified on the EDI Form to begin the testing process.

DATE: _____

OFFICE INFORMATION

GROUP/PROVIDER Name: _____

Group/Provider Federal Tax I.D. #: _____

Contact Name: _____

Contact's E-Mail Address: _____

Phone Number: _____ Fax Number: _____

BUSINESS Address: _____

City: _____ State: _____ Zip code: _____

MAILING Address: _____

City: _____ State: _____ Zip code: _____

BILLING INFORMATION

BILLING AGENT Name: _____

Billing Agent Contact Name: _____

Billing Agent Address: _____

City: _____ State: _____ Zip code: _____

Phone Number: _____ Fax Number: _____

Software Vendor: _____

EDI Clearinghouse: _____

PROVIDER INFORMATION: Please list ALL providers, use back of form if necessary.

Provider Name:

UPIN:

NPI:

HEALTHSPRING EDI DEPARTMENT USE ONLY

Date Rec'd by HealthSpring: _____ HealthSpring Vendor #: _____

Approved ☐ -or- Denied ☐ Date: _____

Comments: _____