Existing Client Registration Form

PLEASE NOTE: This form must be completed separately for each provider/office location combination that you would like added to The Sammy System.

Complete this form online and then print and fax or e-mail it to us. Please do not handwrite on this form.

Individual Provider Information

First Name:	**Last Name:**	**Suffix:**
Individual NPI Number:	**Tax ID:**	**Social Security:** *(Leave this blank if you do not bill any carrier under your social).*
License Number:	**DEA Number:**	**Provider E-mail:**

Service Address *(CMS 1500 form Box 32)*

Street Address:			
City:	**State:**	**Zip + 4:**	**County:**
Phone:		**Fax:**	

Pay to Address *(CMS 1500 form Box 33 if different from service address. Leave blank if it's the same).*

Street Address:			
City:	**State:**	**Zip + 4:**	**County:**
Phone:		**Fax:**	

The information below should only be provided if you bill under a group for one or more insurance companies. If you do not, please leave this section blank.

Group Information

Group Name:		
Organizational NPI Number:	**Group Tax ID:**	**Office E-mail:**

Pay to Address *(CMS 1500 form Box 33 if different from service address in the provider section. Leave blank if it's the same).*

Street Address:			
City:	**State:**	**Zip + 4:**	**County:**
Phone:		**Fax:**	

Existing Client Registration Form

Important Information

It is extremely important that this information is provided to us accurately to ensure timely insurance reimbursements once you are added to Sammy. There will be a $250 implementation fee assessed for each Existing Client Registration Form we process.

ATTENTION GROUPS: If you are a group you MUST fill out both individual information and group information for each insurance carrier. (You are considered a group if you currently get paid under your organizational NPI number).

Please select the option(s) below that apply to your practice:

☐ I will not be sending claims through Sammy. I would just like to be added to the appointment calendar. *(If you select this option, you do not have to complete the remainder of this form except for the signature on the last page).*

☐ Please set me up to send my commercial claims electronically.
☐ Please set me up to send my prescriptions electronically *(e-Prescribing).*
☐ Please set me up for Medicare and Commercial eligibility.
☐ Please set me up for SamNotes *(electronic chart notes)*.
☐ I plan on participating in the MIPS program (Merit Based Incentive Payment System). *(We will contact you to set up the necessary training. Please note that you must have SammyEHR program to receive the maximum incentive payments).*

Our bookkeeping department will send you an invoice or contact you based on the options you select above.

☐ Please set me up to receive electronic remittances (EOB/835) for my commercial carriers. *(We will provide you with a list of companies you may receive electronic remittances from for you to determine which ones you would like to set up).*

Please note: NPI numbers are not the same as provider/PTAN numbers. If you do not know what your numbers are, please contact the individual carriers before completing this form. We need that information to provide you with the necessary paperwork.

Please use this section to provide any information you believe is applicable to the above information you provided:

Existing Client Registration Form

Insurance Information

➢ MEDICARE

Please provide us with a copy of a Medicare EOB (explanation of benefits) or enrollment letter).

Please tell us how you bill Medicare: ☐ I bill under my individual PTAN. ☐ I bill under my social security number.
☐ I bill under my group PTAN. ☐ I bill under my Tax ID number.

Carrier Name (NGS, WPS, etc.):	
Individual Provider Number (PTAN):	**Group Provider Number** *(if applicable)*:

➢ Blue Cross Blue Shield

Please provide us with a copy of a BCBS EOB (explanation of benefits) or enrollment letter.

Please tell us how you bill BCBS: ☐ I bill under my individual PTAN. ☐ I bill under my social security number.
☐ I bill under my group PTAN. ☐ I bill under my Tax ID number.

Carrier Name (Empire, Anthem, Highmark, etc.):	
Individual Provider Number (PTAN):	**Group Provider Number (PTAN)** *(if applicable)*:

➢ Railroad Medicare

Please provide us with a copy of a Medicare EOB (explanation of benefits) or enrollment letter).

Please tell us how you bill Railroad: ☐ I bill under my individual PTAN. ☐ I bill under my social security number.
☐ I bill under my group PTAN. ☐ I bill under my Tax ID number.

Individual Provider Number (PTAN):	**Group Provider Number** *(if applicable)*:

Existing Client Registration Form

➢ CEDI (DMERC)

Please provide us with a copy of a CEDI EOB (explanation of benefits) or enrollment letter).

Please tell us how you bill CEDI/DMERC:
- ☐ I bill under my social security number.
- ☐ I bill under my Tax ID number. (*If you bill DMERC under a TaxID, you must include an organizational NPI number in the group section on page 2).*
- ☐ I have a separate NPI number for DMERC which is:

Supplier Number/PTAN:	**Tax ID***:	**Social Security**:

➢ Medicaid

Please tell us how you bill Medicaid:
- ☐ I bill under my individual PTAN.
- ☐ I bill under my group PTAN.
- ☐ I bill under my social security number.
- ☐ I bill under my Tax ID number.

Individual Provider Number (PTAN):	**Group Provider Number** *(if applicable)*:

➢ CDPHP

Please tell us how you bill CDPHP:
- ☐ I bill under my individual PTAN.
- ☐ I bill under my group PTAN.
- ☐ I bill under my social security number.
- ☐ I bill under my Tax ID number.

Individual Provider Number (PTAN):	**Group Provider Number** *(if applicable)*:

➢ Commercial Carriers (Zip Claim/Emdeon)

Provider Specialty:		
INFORMATION BELOW IS TO BE COMPLETED BY ICS		
TSO:	**Site ID:**	**External ID:**

Provider Signature: _____ Date: _____

You will receive an invoice for $250 upon receipt of this form which must be paid prior to the paperwork process.

We will use the information provided on this form to provide you with instructions on adding your new provider to your existing electronic submitter numbers. ***Please make sure you include copies of your insurance EOB's for the carriers you included information for above to ensure timely and accurate paperwork processing.***

Please fax to: 516-632-7078