# Existing Client Registration Form

**Legal Company Name:** _____ **Provider Name:** _____

**Important Information:**

- This form must be **completed separately for each provider/office location combination** that you would like added to The Sammy System**. 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).
- 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.
- **Processing fee:** You will receive an invoice for $250 upon receipt of this form which must be paid prior to the paperwork process *(this fee will not be assessed if this form is only being used for change of address)*. Based on the selections you make below; our finance team will also send you an invoice or contact you to discuss.
- **Processing time:** Please allow 5-7 business days for processing of paperwork and order form to be sent to you.

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

☐ I am replacing an existing provider in the practice (Do not check if you are an add-on provider)
☐ 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. No other settings, including billing will be set up or added to Sammy.)*
☐ I need to change my practice address.
☐ Set me up to send my commercial claims electronically.
☐ Set me up for MX Appointment reminders.
☐ Set me up to send my prescriptions electronically *(e-Prescribing).* (Please provide copies of your DEA, medical and driver's licenses)
☐ Set me up to send controlled substances (EPCS) electronically.
☐ Set me up for Medicare and Commercial eligibility.
☐ Set me up for SamNotes *(electronic chart notes)*.
☐ Set me up to receive electronic remittances (EOB/835s) 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).*

**Complete this form online and then print, sign and fax or email it to us.**
**Please do not handwrite on this form. Any forms received unsigned will not be processed and will be returned for signature.**

# Existing Client Registration Form

**Complete this form online and then print and fax or email 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:** |

# 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)*: |
| **If your practice is in these states: AZ, CA, FL, ID, IL, LA, MN, NM, OK, OR, TX, WA provide your Availity username and password:** | |

### 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)*: |
|---|---|
| **If your practice is in these states: FL, IL, MI provide your web portal username and password:** | |

## Commercial Carriers (Zip Claim/Emdeon)

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

Provider Signature: _____ Date: _____

*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.***

**Within 5-7 business days of receiving this form, we will send you an order form requiring signature and approval. What email should we send the order form to?**

**Email address:** _____

**Please fax to: 516-632-7078**