Horizon Blue Cross Blue Shield of New Jersey

Making Healthcare Work.

HORIZON BLUE CROSS BLUE SHIELD OF NEW JERSEY
ELECTRONIC TRANSACTION AUTHORIZATION FORM

Health Care Professional, Hospital, Facility or Trading Partner Name: ______________________

Address: ______________________

City: ______________________ State: ________ ZIP: __________

Contact: ______________________

Phone: ______________________ Fax: ______________________

E-mail Address: ______________________

Tax ID: ______________________ Group NPI Number: ______________________
(Required for Hospital, Facility, Physician & Other Health Care Professional)

Individual NPI Number: ______________________

Alpha Suffix(s): ______________________ Sub Part ID Number: ______________________
(Required for Multi specialty Groups with assigned suffix)

Hospital and Facility Number: ______________________ Sub Part ID Number: ______________________
(Required for Hospital and Facility only)

Mode of Transmission:

Please check only one.

Specific to:	Rules and Regulations
☐ **Notice of Admission/ Request for Authorization**	We agree that any and all Notice of Admissions/Req Auths sent electronically contain true, accurate and complete information. We agree that it is our responsibility to assure that Horizon BCBSNJ has received our Notice of Admissions/ Req Auths by reconciling response reports returned to us.
☐ ***Clearinghouse Or** ☐ ***Billing Service**	We agree to authorize the billing service or clearinghouse named below to submit our Horizon BCBSNJ claims electronically. We realize that it is our responsibility to assure that we receive from our billing service or clearinghouse any and all reports that are sent electronically from Horizon BCBSNJ to our billing service or clearinghouse detailing the results of our transmission(s). We agree to notify Horizon BCBSNJ if we discontinue sending electronic transmission through the below named trading partner and before beginning to use any other trading partner to send electronic transmissions.
☐ **Hospital, Facility, Physician or Other Health Care Professional Programming Horizon BCBSNJ Specification**	We agree to fully program all aspects of the Horizon BCBSNJ Specification for the transactions we desire to send electronically to assure accurate and complete data transmission. We agree to program all transaction specific edits as outlined in the Horizon BCBSNJ Specification to assure a limited number of rejects. We agree to make all programming changes requested by Horizon BCBSNJ as promptly as reasonably possible. We agree to maintain the confidentiality of our Test and Production Submission IDs and Passwords and prevent unauthorized users from committing data security violations with our Submission IDs and Passwords. We realize that it is our responsibility to retrieve any and all reports that are put in our electronic mailbox by Horizon BCBSNJ detailing the results of our transmission(s). We agree to notify Horizon BCBSNJ if we discontinue sending electronic transmissions and before beginning to use other means of electronic transmissions.

*If you checked Software Vendor, Clearinghouse or Billing Service ("Trading Partner"), please provide the name of your software vendor, clearinghouse, or billing service below:

Name of Trading Partner: ______________________

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Electronic Transactions Available:

Please check ***ONLY*** the electronic transactions that you are applying for:

Claims: ☐ **Physician or other Health Care Professional** **Or** ☐ **Hospital or Facility**	We agree that the information on claims submitted electronically will be true, accurate and complete; and agree to keep such records as are necessary to disclose fully the extent of services and allow Horizon BCBSNJ reasonable access to all source documents and medical records related to any claim. We accept the liability for all claims submitted to Horizon BCBSNJ and will promptly refund any overpayment made by Horizon BCBSNJ on electronic claims. We realize that anyone who falsifies electronic claims information may, on conviction, be subject to fines and/or imprisonment under Federal Law. We agree that it is our responsibility to reconcile claim response reports / messages received from Horizon BCBSNJ, including acknowledgement of claim receipt from Horizon BCBSNJ, to assure our claims were received by Horizon BCBSNJ.
☐ **Requests for Authorization (Req Auth)**	We agree that any and all Req Auths sent electronically contain true, accurate and complete information. We agree that it is our responsibility to assure that Horizon BCBSNJ has received our Req Auths by reconciling response reports returned to us.
☐ **Eligibility**	We realize that the eligibility information returned by Horizon BCBSNJ is contingent on the information available at the moment of transmission. We understand that eligibility for a particular patient may change between the time of inquiry and the time the claim is processed. Payment determinations will be made based on eligibility at the time that services are provided.
☐ **Referrals**	We agree that any and all information contained on our electronic referrals is based on medical necessity. We understand that acceptance of this referral does not guarantee payment. We understand that payments are determined based on contracts and contract limitations. We agree that it is our responsibility to assure that Horizon BCBSNJ has received our referrals by reconciling response reports returned to us.
☐ **Premium Payment**	We realize that this transaction is used for the purpose of reporting payroll deducted and other group premiums for all users sending premium payments to Horizon BCBSNJ. We agree that it is our responsibility to ensure funds are available to cover premiums.
☐ **Benefit Enrollment**	We agree that the information submitted electronically will be true, accurate and complete. We realize this transaction is used only to transfer enrollment information from the sponsor of the insurance coverage, benefits, or policy to Horizon BCBSNJ. We accept the liability for all files submitted to Horizon BCBSNJ.
☐ **Claim Status**	We realize that the request for the status of a health care claim or encounter is contingent on the claim information available at the time of transmission.

Signature ______________________ Title ______________________

Print/Type Name ______________________ Date ______________________

Mail or Fax completed form to:

Horizon Blue Cross Blue Shield of New Jersey
EDI Services PP-11C
3 Penn Plaza East
Newark, NJ 07105-2200
Fax Number: 1-973-274-4353

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