



Wisconsin Physicians Service Insurance Corporation
1717 W. Broadway
P.O. Box 8128
Madison, WI 53708-8190
Phone: (608) 221-4711

Reminders: Please be sure to sign Item 16, Exhibit A!
Complete and return all 5 pages

Dear EPIC Provider:

Thank you for choosing the electronic method for submission of your healthcare claims. The EPIC Life Insurance Company requires that all new electronic providers/groups sign, and have on file, a "Provider Agreement to Submit Electronic Media Claims" prior to submitting electronic claims. We request that you complete and return this agreement form, including this cover letter, to our office.

An organization that has several providers can execute a single Provider Agreement form on behalf of the group. Only one authorizing individual is needed to sign the agreement for the Clinic/Group. However, we do need a complete list of all physicians for which you will be billing (as indicated in Exhibit B - EPIC Provider Enrollment Form).

If you will be submitting claims through a Billing Service/Clearinghouse, please indicate their name below.

Billing Service/Clearinghouse Name: _____

This agreement must contain an original signature. A faxed copy will not be accepted, therefore, this must be mailed to:

Electronic Data Services
Wisconsin Physicians Service
P.O. Box 8128
Madison, WI 53708

Thank you for your cooperation.

Sincerely,

Electronic Data Services
Wisconsin Physicians Service

EXHIBIT A

PROVIDER AGREEMENT TO SUBMIT ELECTRONIC DATA INTERCHANGE CLAIMS FOR REIMBURSEMENT BY THE EPIC LIFE INSURANCE COMPANY

It is hereby agreed between The EPIC Life Insurance Company (hereinafter referred to as EPIC), and the undersigned health care provider, (hereinafter referred to as "Provider"), that said Provider is appointed to submit claims via electronic media for reimbursement by EPIC for services rendered to EPIC health plan subscribers and dependents. This appointment is conditioned upon the Provider fully agreeing to and following all of the terms and conditions set forth in this Agreement, the Attachment A as applicable and clearing EPIC internal provider review standards for acceptance and payment of EDI submitted claims.

TERMS AND CONDITIONS

1. In submitting Electronic Data Interchange claims, Provider agrees to submit such claims edited and formatted according to the specifications indicated within the user's guide supplied by EPIC. Provider understands the EPIC EDI user's guide is proprietary and is authorized for use only by Provider and its employees working on its behalf to submit such electronic media claims. Any other use or distribution of the EPIC EDI user's guide is strictly prohibited without the express written consent of EPIC. EPIC shall be the final authority in resolving any discrepancies in how electronic data shall be submitted.
2. Provider agrees that each and every claim submitted via electronic media, for all legal and other purposes, will be considered signed by the Provider or Provider's authorized representative.
3. Provider agrees to maintain a patient signature file. Provider understands EPIC may validate through file audits, those claims submitted via electronic media which are included in any quality control or sampling method requested by EPIC. Provider understands if no signed authorization is on file, an authorization must be obtained prior to claim submission.
4. Provider agrees that EPIC or representatives of EPIC, have the right to audit and confirm any source documents, including, but not limited to, medical records, claim forms, and Explanation of Benefits from Primary Carriers, that are relevant to claims submitted to EPIC electronically. Any incorrect payments which are discovered as a result of such an audit will be appropriately adjusted.
5. Provider will ensure that each electronic data interchange claim submitted can be readily associated with all source documents in an auditable fashion for no less than seventy-two (72) months following the date of payment by EPIC. All medical records will be maintained according to the laws of the state in which the services are provided.
6. Provider agrees to establish and maintain procedures so that information concerning EPIC subscribers and dependents or any information obtained from EPIC shall not be used by Provider or Provider's agents, officers or employees except as provided by Federal or State Law including the Freedom of Information Act, Drug Abuse Office and Treatment Act (42 U.S.C. s290ee-3) and the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act (42 U.S.C. s290dd-3). Provider agrees not to disclose any information concerning a EPIC subscriber to any person or organization other than EPIC, without the express written permission of the EPIC subscriber or his lawful representative.

7. The undersigned provider understands that the submission of an electronic data interchange claim to EPIC is a claim for EPIC payment and that any misrepresentation or falsification of records relating to that claim is Subject to prosecution under federal criminal and civil law and the laws of the State of Wisconsin and, upon conviction, will result in fines and/or imprisonment.
8. This agreement may be terminated at any time by either party to this Agreement by giving five (5) days written notice of such termination to the other party.
9. Provider agrees that EPIC may test any submission against validity and consistency edits as defined in the user's guide provided by EPIC. Provider understands that EPIC will accept all valid claims which meet such edit requirements and return such errant submissions for correction.

In the event that errors are identified on claims which pass these edits and have been accepted into the EPIC adjudication system, EPIC will work with the Provider to remedy such errors. However, data errors submitted by Provider will be identified to the Provider in writing by EPIC and Provider will remedy such errors within five (5) working days or face possible suspension from the EDI program or termination of this Agreement.

10. EPIC reserves the right to refuse for any reason to accept electronic data interchange claims covered by this Agreement.
11. All required notices under this Agreement shall be sent by certified mail, postage prepaid, return receipt requested.

The signed agreement or any questions related to the agreement shall be mailed to:

Electronic Data Services
Wisconsin Physicians Service
PO Box 8128
Engel Street
Madison, WI 53708

If such notice is sent to the Provider, it will be addressed to the individual named in the Provider's signature blank below, and sent to the mailing address shown below for the Provider.

12. This Agreement may not be modified or changed orally. All modifications must be made in writing signed by both parties.
13. The interpretation and legal effect of this Agreement shall be governed by the laws of the State of Wisconsin.
14. This Agreement shall be binding upon, and inure to the benefit of the successors, assigns and legal representatives of each of the parties hereto. However, it shall not be assigned by either party without the written consent of the other party.
15. It is agreed that the relationship of the parties hereto is that of independent contractors and this Agreement does not constitute either party as agent, partner or employee of the other party.
16. By executing this Agreement below, Provider agrees to all of the terms and conditions of the Agreement. Provider further agrees to begin to submit claims electronically only after Provider has received a written notice from EPIC stating permission to do so has been granted.

THE EPIC LIFE INSURANCE COMPANY

Name of Provider

Tax ID Number of Provider

Mailing Address

By _____
Signature and Title of Provider
or Authorized Officer

Date

By _____
EPIC Authorized Signature

Date

EXHIBIT B

EPIC PROVIDER ENROLLMENT FORM – EDI

Please complete and return this form before submitting test claims to The EPIC Life Insurance Company.

Name of your practice: _____

Federal Tax I.D. #: _____

Physical Address of Your Practice: _____

City _____ State _____ Zip Code _____

Billing Location for Your Practice : _____

Clinic Contact (please print) : _____

Telephone _____ Ext. _____ E-mail address: _____

***If your computer system can generate a list of all physicians you will be billing for (including their full name & state license number/Social Security number) you DO NOT need to complete the information below.**

Information for Providers at this Location:

1. Name and Title of Provider _____
State License # _____ Specialty _____
Soc Security # _____ Board Certified w/in Specialty ___ Yes ___ No
What date did you begin practicing at this location? _____
What date did you terminate from this location? _____

2. Name and Title of Provider _____
State License # _____ Specialty _____
Soc Security # _____ Board Certified w/in Specialty ___ Yes ___ No
What date did you begin practicing at this location? _____
What date did you terminate from this location? _____

RETURN COMPLETED FORM TO: Electronic Data Services
Wisconsin Physicians Service
PO Box 8128
Madison, Wisconsin 53708