



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

Dear Provider:

Thank you for choosing the WPS Provider Corner for your ability and claim status inquiries. Please sign and return the attached agreement.

A faxed copy, e-mailed copy, or original will be accepted. Please mail, fax or e-mail your completed agreement to:

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

Fax: (608)223-3824
E-mail: edi@wpsic.com

If you self registered as a submitter through the WPS Trade Partner System (WTPS), please provide the submitter number assigned to you: _____.

Thanks you for your cooperation.

Sincerely,

Electronic Data Services
Wisconsin Physicians Service



WPS INTERNET WEBSITE USER AGREEMENT

It is hereby agreed between Wisconsin Physicians Service Insurance Corporation (hereinafter referred to as "WPS") and the undersigned health care provider (hereinafter referred to as "Provider"), that Provider is appointed as a non-exclusive user of the WPS Information System (hereinafter referred to as "System"). Provider is authorized to access WPS' designated Website via the Internet to view and receive eligibility and/or claims status information and may use this information to determine that the patient is eligible for available benefits, if any by WPS and/or The EPIC Insurance Company, WPS' wholly-owned subsidiary (hereinafter referred to as "EPIC"). Provider is authorized to submit health insurance claims electronically to WPS for processing and payment of available benefits. This appointment is conditioned upon the Provider fully agreeing to the terms and conditions set forth in the Agreement and meeting WPS' and/or EPIC's internal provider review standards, as determined by WPS and/or EPIC.

1. Provider agrees to submit claims electronically to WPS and/or EPIC using compatible software and hardware, in order to participate in the WPS Internet eligibility/claims status/claims submission initiative. Provider agrees to submit said claims electronically in accordance with and be bound by, the rules and procedures that WPS has and will establish for the System. Provider also agrees to use said information only for the valid business purposes approved by WPS.
2. Provider agrees to establish and maintain rules and procedures so that information concerning WPS and/or EPIC customers and dependents, or any information obtained from the System, shall not be used by Provider or Provider's officers, employees or agents, except in accordance with federal or state laws, including, but not limited to, the Health Insurance Portability and Accountability Act, the Freedom of Information Act and the confidentiality of records provisions of the Alcohol, Drug Abuse and Mental Health Administration Reorganization Act (42 U.S.C. §290dd-2). Provider agrees not to disclose any information concerning a WPS and/or EPIC customer or dependent to any person or organization other than WPS and/or EPIC, without the express written permission of the customer or his lawful representative. As a user, Provider must comply fully with all applicable federal, state, and local laws, including, but not limited to, laws requiring Provider to exercise due diligence to prevent unauthorized disclosure or improper use of this information for any purpose not specifically intended by this System. The Provider is solely liable and responsible for its own acts and/or omissions and those of its employees, agents and officers, while using this System; Provider understands and agrees WPS and EPIC have no liability or responsibility whatsoever for said acts and/or omissions.
3. This Agreement may be terminated at any time by either party to this Agreement by giving at least five (5) days advance written notice of such termination to the other party.
4. All required notices under this Agreement shall be sent by certified mail, postage prepaid and return receipt requested.

This signed Agreement or any question related to this Agreement shall be mailed to:

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

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

5. This Agreement may not be modified or changed orally. All modifications must be made in writing and signed by the parties.
6. The laws of the State of Wisconsin shall govern the interpretation and legal effect of this Agreement.
7. This Agreement shall be binding upon, and inure to the benefit, of the successors, assigns and legal representatives of each of the parties. However, it shall not be assigned by either party without the written consent of the other party, which shall not be withheld unreasonably.

8. It is agreed that the relationship of the parties is that of independent contractors and this Agreement does not constitute either party as agent, partner or employee of the other party.
9. The system contains sensitive, confidential and proprietary medical benefit plan and financial information and must be protected against unauthorized disclosure, release, modification or other action. By entering into this Agreement, Provider agrees to treat said information as confidential and to preserve its confidentiality in accordance with applicable laws and WPS' rules and procedures for users of the System. Provider also understands and agrees that said information is subject to change, said information does change and that WPS relies on information provided by other sources not within WPS' and/or EPIC's control. As a result, WPS makes no warranty or guarantee concerning the accuracy or reliability of the content of said information available at the WPS Website or other Internet Websites to which WPS' Website is linked, if any.
10. Provider understands and agrees that its use of the System and/or said information does not guarantee payment of benefits by WPS and/or EPIC, or that any treatment, service or supply provided to any patient is covered by WPS and/or EPIC. Provider further understands and agrees that WPS' and/or EPIC's claim processing decisions about payment can only be made by WPS and/or EPIC when all necessary claim information is received and reviewed by WPS and/or EPIC in accordance with all terms, conditions and provisions, including, but not limited to, exclusions or the applicable benefit plans.
11. By executing this Agreement below, Provider agrees to all terms and conditions of the Agreement.

Provider's Name	Full Name (First, MI, Last)
Location/Department	Title
	Signature of Provider or Authorized Officer
Mailing Address	Name
Office Phone	Date
Fax Number	For Wisconsin Physicians Service Insurance Corporation
Provider's Status (Check one below)	WPS Authorized Representative
<input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Sole proprietorship <input type="checkbox"/> Other (Identify)	Name
	Date

WPS INTERNET WEBSITE SUBMITTER PROFILE

Please complete and return this form along with the "WPS INTERNET WEBSITE USER AGREEMENT"

- Reason for Submission:
- Applies to All Locations
 - Applies to only Certain Locations. Please provide a list of the locations
 - Change in Primary or Secondary Contact

TODAY'S DATE	
NAME OF YOUR PRACTICE	
TAX ID NUMBER	
EDI SUBMITTER NUMBER OR CLEARINGHOUSE NAME <i>(if filing claims electronically to WPS)</i>	
STREET ADDRESS	
CITY, STATE, ZIP CODE	
PRIMARY CONTACT PERSON	
PRIMARY CONTACT E-MAIL ADDRESS	
PRIMARY CONTACT PHONE	
SECONDARY CONTACT PERSON	
SECONDARY CONTACT PHONE	
SECONDARY CONTACT E-MAIL ADDRESS	

UNIQUE SECURITY IDENTIFIER

The Unique Identifier is a voice password created by your office. This voice password allows you to have your original WPS Provider Corner system password reset by WPS Electronic Data Services Help Desk staff in the event you forget your system password. This process ensures your WPS Provider Corner user ID and password are not obtained by outside sources. The Unique Identifier can be any word or phrase. Please make sure your secondary contact has this information in the event you are not able to call personally.

FOR WPS USE ONLY – WPS will complete information below and return to your office.

You will be prompted to change the WPS Provider Corner user password when you sign on to the system for the first time. If you forget your password, contact WPS; confirmation of user identity will be required prior to issuing a new password.

WPS Provider Corner User Name _____

Unique Identifier User Name _____

User Name and password control access to the processing system. You must have this information available each time you sign on to WPS Provider Corner.

Date Activated: _____