DATA-DRIVEN HEALTHCARE SOLUTIONS

HUMANA SETUP FORM INSTRUCTIONS (61101)

PRINT these instructions. Refer to them as you complete the registration process.

Please type provider information on the form for ease of processing.

If you are a billing service completing this form on behalf of a provider, complete the top section of this form.
If you use a third-party billing service to prepare your claims, complete the top section of this form.
MD On-Line is not a billing service.
If you do not use a third-party billing service to prepare your claims, skip to the middle of this form.

Complete this form using group provider information as listed on file with the payer you wish to set up.
If you are unsure what information the payer has on file for you, contact the payer – MD On-Line cannot obtain this information for you.

IMPORTANT: You must include your Billing NPI and any applicable Provider IDs.
Forms submitted without a Billing NPI WILL BE RETURNED TO YOU.

IMPORTANT: You must specify the payer(s) with which you wish to enroll in ERA.
If you do not specify any payers, your enrollment form WILL BE RETURNED TO YOU.
If you wish to receive ERA from any additional payers, add them in the space provided. Make copies of this form if necessary.

Humana requires providers to complete an online enrollment process and setup for EFT. You will receive instructions to complete this process once we receive your setup form. Please be sure to include a valid contact Email address.

Click the "SUBMIT" button to send your form to Enrollment when completed.

Have questions or need assistance? Contact the MD On-Line Enrollment Department at 888-499-5465 x3506 or setup@mdol.com

Please complete one Contract Setup Form per Tax ID. Return the form to MD On-Line's Enrollment Department with your EDI documentation. All information is required.

If you use a third-party billing service to **prepare** your claims, complete this section (**if not, skip to the provider info section**):

Billing Service Name: _____ **TIN/MDOL ID**: _____

Contact Name: _____ **Phone:** _____

Group/Provider Name: _____

Billing Tax ID: _____ **Indicate** Tax ID: ☐ SSN: ☐

Address on file with Payer(s): _____

City: _____ **State:** _____ **ZIP+4:** _____

Street Address/Practice Location on file with Payer(s): _____

City: _____ **State:** _____ **ZIP+4:** _____

PRINT Authorized signature name, title (CEO, etc): _____

Contact FULL NAME: _____ **Phone:**_____

Contact Fax: _____ **Email:** _____

Please list the carriers with which you wish to enroll below. Review the MDOL Payer List for enrollment requirements.

PAYER ID	PAYER NAME	PTAN	RENDERING NPI	BILLING NPI	CLAIMS	ERA
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐
					☐	☐