



**SCHEDULE CR  
TO  
CONSENT TO RECEIVE ELECTRONIC REMITS**

**AGENT ADDENDUM**

This Addendum to the attached Agreement of Consent to Submit Claims Electronically (“Agreement”) acknowledges that Trading Partner has entered into an arrangement with \_\_\_\_\_, with its principle place of business at \_\_\_\_\_ (“Agent”) to provide third party services to Trading Partner.

1. **APPOINTMENT.**

Trading Partner has appointed an Agent to provide certain services to Trading Partner that necessitate Agent being able to take advantage of the electronic services as described in the attached Agreement is being made available to Trading Partner in accordance.

2. **ACCESS.**

Health Plan shall provide the electronic services to Agent upon the same terms and conditions of the Agreement to be provided to Trading Partner.

3. **OBLIGATION OF AGENT.**

Agent shall have the same duties, rights and obligations as Trading Partner has agreed to under the terms of the Agreement.

4. **NOTICES.**

Any notices required or permitted to be given pursuant to this Addendum shall be in writing and addressed to the following mailing address or such other address as may be provided to the other in writing:

AGENT

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Excellus Health Plan, Inc.  
EDI Solutions  
P.O. Box 22999  
Rochester, NY 14692**

5. **INCORPORATION.**

All terms and conditions of the Agreement are incorporated by reference into this Addendum. The Parties hereby agree to the provisions of the Addendum.

6. **SIGNATURES (REQUIRED):**

PHYSICIAN (S):

\_\_\_\_\_

Title: \_\_\_\_\_

Dated: \_\_\_\_\_

AGENT’S NAME:

\_\_\_\_\_

Title: \_\_\_\_\_

Dated: \_\_\_\_\_



**Mail to:**

Excellus Health Plan, Inc.  
EDI Solutions  
P.O. Box 22999  
Rochester, NY 14692

**Practice Information**

Practice Name: \_\_\_\_\_

Practice Address: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_ Zip: \_\_\_\_\_

Practice Contact

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Practice NPI: \_\_\_\_\_

Practice Tax Id Number: \_\_\_\_\_

Billing Service: Yes ( ) No ( )

*\*If yes, please be sure to complete the following. If no, please skip to 'Software Vendor'*

**Billing Service/Clearinghouse Information**

Billing Service:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Clearinghouse:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Email: \_\_\_\_\_

Submitter ID: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Signature: \_\_\_\_\_

**\*\*Signature required by physician or authorized person to sign on behalf of practice**



Software Vendor

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Submitter ID: \_\_\_\_\_

Effective Date: \_\_\_\_\_

Signature: \_\_\_\_\_

\*\*Signature required by physician or authorized person to sign on behalf of practice