univera HEALTHCARE

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 it 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
_____
_____
_____

Univera Healthcare
EDI Solutions
P.O. Box 23000
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: _____

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Mail to:
Univera Healthcare
EDI Solutions
P.O. Box 23000
Rochester, NY 14647

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

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Software Vendor

Name:_____

Phone:_____

Submitter ID:_____

Effective Date:_____

Signature:_____

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