

# HealthWare EDI Registration Form

**Please complete one form for each doctor in practice.**

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

Dentist Name \_\_\_\_\_

Address \_\_\_\_\_

City, State and Zip code \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Contact \_\_\_\_\_

BILLING FEDERAL TAX ID # \_\_\_\_\_

PROVIDER'S SOCIAL SECURITY # \_\_\_\_\_

NATIONAL PROVIDER ID # \_\_\_\_\_

PROVIDER'S STATE LICENSE # \_\_\_\_\_

PRACTICE MANAGEMENT SOFTWARE \_\_\_\_\_ VERSION \_\_\_\_\_

HIGH SPEED INTERNET ACCESS (e.g. Cable or DSL) YES \_\_\_\_\_ NO \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_

The undersigned hereby agrees and authorizes HealthWare Inc. to keep my signature on file and to charge the bankcard account identified below for all amounts due to HealthWare Inc. for electronic claims submission. Debits will be made on approximately the 1<sup>st</sup> of each month. If claims activity charges do not exceed \$15.00, a \$15.00 minimum charge will be debited.

PLEASE CIRCLE ONE: VISA or MASTERCARD

ACCT# \_\_\_\_\_ EXP. \_\_\_/\_\_\_

Name (as it appears on card) \_\_\_\_\_ (Please Print)

Credit card billing address (if different than above)

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

I agree to submit my claims through software provided to me by HealthWare Inc. I hereby appoint HealthWare Inc. to be my agent when necessary for the submission of our claims. I will pay HealthWare Inc. \$.30 per claim for all claims submitted. HealthWare Inc. makes no warranty, expressed or implied for its services hereunder. I understand that if HealthWare Inc. makes any error that causes a claim to be rejected, the error will be corrected and the claim will be resubmitted to the payor at no additional charge to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

HealthWare Inc. – P.O. Box 71663, Madison Heights, MI 48071  
Phone (866)332-5849 Fax (248)733-9989