

SecureConnect Agreement

Complete one form per Group using SecureConnect

Please Check (1) Medical Helper Therapist Helper

Customer Account Number: _____ Contact Name: _____

Authorized Signature: _____ Date: _____

By signing this document I have read and agree to pay the SecureConnect monthly billing fees.

SecureConnect Pricing (See page 3)

Please specify which payment Option. See pricing sheet for option details

Options A: Per Claim Pricing Option B: Unlimited per Provider

Please contact your Sales Representative for more questions on pricing

This service requires the following:

-Active Helper Maintenance Contract.

-Internet Connection or dialup modem.

- There are no refunds on SecureConnect Signups, Maintenance Contracts or Upgrades
- It is the user's responsibility to terminate the SecureConnect service, by submitting a written notice
- Monthly fees will be charged whether or not claims are submitted, until either party cancels the service.

Payment Method: *If paying monthly fees by credit card, we allow one credit card per site.*

(Circle One): Visa MasterCard Discover AMEX or **CHECK** (Make payable to: **VantageMed**)

Credit Card #: _____ Exp. Date: _____

Signature: _____ I authorize VantageMed to charge my card \$75 sign-up fee for the first provider and \$10 for each additional provider

Signature: _____ I authorize VantageMed to charge my monthly fees incurred for e-Claims and e-Statements.

Please mail both forms to:

VantageMed
SecureConnect CLAIMS DEPT.
600 W. Cummings Park, Suite 3450
Woburn, MA 01801

= OR =

Fax both forms to:

SecureConnect CLAIMS DEPT.
(781) 937-3232

Please note: You must return: one completed agreement form for the group, a provider set up form for each provider who wants to use SeucureConnect a long with the \$75 setup fee for the first provider and \$10 for each additional provider. We will mail you instructions to get started using SecureConnect and all forms needed to enroll electronically for specific Payers. Thank you.

New Group/Provider Information Sign-Up Forms

Please fax completed form to SecureConnect Enrollment: (781) 937-3232 or mail to:

VantageMed - SecureConnect
600 W. Cummings Park, Suite 3450
Woburn, MA 01801

VantageMed Account Number: _____

FACILITY INFORMATION *(Please fill out all information - Incomplete forms will be returned)*

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Contact: _____ Phone: _____

Email: _____ Fax: _____

PROVIDER INFORMATION *(complete one form for each provider)*

Provider Name: _____ Degree: _____ License #: _____

Tax ID: _____ Check off appropriate box: EIN SSN

Provider Specialty Code: _____ or Name of Specialty: _____

PAYER SELECTION

Check the payer(s) to whom you plan to submit electronic claims and add providers numbers. If any payers selected require enrollment, the appropriate payer agreements will be sent to you after VantageMed has processed this form.

				*** For VantageMed Use Only ***		
Payer Name	Individual Provider Numbers	Group Group Numbers	State	Payer Id	Enrollment	Route
<input type="checkbox"/> NPI Provider Number			State _____			
<input type="checkbox"/> BlueCross/Blue Shield			State _____		<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Medicare			State _____		<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Medicaid			State _____		<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> TriCare/Champus			State _____		<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> RR Medicare			State _____		<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> DMERC			Region _____		<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Magellan					<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> ValueOptions					<input type="checkbox"/> Y <input type="checkbox"/> N	
<input type="checkbox"/> Commercials Payers	No Enrollment Required				<input type="checkbox"/> Y <input type="checkbox"/> N	

*If provider has been issued more than one provider number for one payer, please complete an additional Provider Setup Information Form for each set of numbers. Failure to indicate multiple provider numbers will result in setup errors. **NOTE: if any changes occur regarding the payers you've selected on this form, the provider numbers for the payers selected, or to your tax ID and or social security numbers, please contact Helper support. Thank you!***