

Emdeon Provider Enrollment Form

Electronic Claims, Statements, and ERA Enrollment Forms

Thank you for choosing MediPro and Emdeon for your EDI solution. Please follow the instructions included in this document very carefully to avoid any unnecessary processing delays. If you have any questions, please contact us at 1.800.759.1321

Pricing Information

Emdeon Office includes the following services:

- Electronic Claims Processing
- Eligibility Checking with Batch Processing*
- Real-time Claim Status
- Claim Tracker
- Referrals
- Authorizations
- Pre-Certifications

Emdeon Office Pricing Options		Pricing			
Setup Fee – Lytec PMS		\$175.00			
Setup Fee – Other PMS		\$225.00			
Number of Providers	Monthly Charge	Transaction Cap**	Monthly Charge with ERA	Transaction Cap with ERA**	
1 Provider	\$79.00	1000	\$119.00	2000	
2 Providers	\$134.00	2000	\$204.00	4000	
3 Providers	\$189.00	3000	\$294.00	6000	
4 Providers	\$244.00	4000	\$374.00	8000	
5 Providers	\$299.00	5000	\$449.00	10000	
6 or More Providers	Please call for special pricing				
Transaction fee above cap		\$0.20			
Optional Services		Pricing			
Electronic Paper Claims		\$0.44			
Electronic Patient Statements		\$0.62			
- Additional Patient Statement Pages		\$0.27			
- FASTforward SM Address Correction Service		\$0.40/Correction			
Direct Claim Entry – Enter claims directly into Emdeon Office (does not require a practice management system)		\$10.00/Month/Provider Extra Setup Fee is \$325.00			

* Some payers charge a fee for eligibility verification. You are responsible for paying these charges. Please see the enclosed list for specific payers that impose these fees.

** Total transactions include (claims, real-time transactions and ERA).

Please DO NOT fax payer agreements to us. All agreements must be mailed to us. Original signatures are required and faxes will not be accepted.

Emdeon Office VAR – End User Setup Form

Instructions:

1. Please fill out this form completely.
2. If payer agreements are not required, fax this form to 770.456.5049
3. If payer agreements are required, mail this form and the payer agreements to:

MediPro, Inc.
 Attn: Emdeon Enrollment
 1301 Shiloh Road, Suite 1250
 Kennesaw, GA 30144

Please DO NOT fax payer agreements to us. All agreements must be mailed to us. Original signatures are required and faxes will not be accepted.

VAR Information

VAR Customer #: [900425536](#) File ID: [12157](#) Contract ID: (Assigned by Emdeon upon receipt)
 Vendor ID: [200305979](#)

Organization Information		Mailing Information (for Notifications)	
Organization Tax ID		<input type="checkbox"/> Same as Organization	
Customer Name		Customer Name	
Primary Contact	Primary Contact Email	Primary Contact	
Address		Address	
City		City	
State	Zip	State	Zip
Telephone	Fax	Telephone	Fax

Billing Information (for Invoices)

Customer Name: [Medipro, Inc.](#)
 Primary Contact: [Marcus Zuckerman](#)
 Primary Contact Email: marcus@medipro.com
 Address: [1301 Shiloh Road, Suite 1250](#)
 City: [Kennesaw](#)
 State: [GA](#)
 Zip: [30144](#)
 Telephone: [770-953-3546](#)
 Fax: [770-456-5049](#)

Primary Contact Information

The designated user will serve as the Primary Contact for the Customer Organization. All changes, including adding or deleting users, services, or payers must be approved by the Primary Contact. All correspondence between Emdeon and the Customer Organization, including welcome letters containing each user’s Emdeon Office User ID and temporary password, will be directed to the Primary Contact. The Primary Contact will serve as site administrator and will have the ability to create additional users online as needed.

Preferred User Name*	MP	Date of Birth	
First Name		Title/Role	
Middle Initial		Gender (M/F)	
Last Name		User receives real-time transactions?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Last 4 Digits of SSN		User receives claim reports?	<input type="checkbox"/> Yes <input type="checkbox"/> No

*If the requested user name is already in use, Emdeon will attempt to assign a similar unique user name.

Emdeon Office VAR – End User Setup Form

Customer Name:

Pricing

Setup Type:	<input type="checkbox"/> Claims and Real-time <input type="checkbox"/> Real-time Only <input type="checkbox"/> ERA Included
Pricing Package Name:	

Additional Enrollment - Payers

Payer lists and payer agreements are available online at: <http://www.emdeon.com/PayerLists/payerlists.php>. If your client would like to submit to payers requiring additional enrollment information, please have them complete and return the necessary forms to you. The payer-specific forms will be required along with this setup.

Real-time Payers

Forms for these payers can be found at the above link. Please select the real-time payers to which your client would like to submit transactions:

Additional Enrollment Form Required:

- BLUE CROSS BLUE SHIELD OF GEORGIA
- NEW YORK MEDICAID
- BLUE CROSS BLUE SHIELD OF MINNESOTA
- BLUE CROSS BLUE SHIELD OF PENNSYLVANIA
- FLORIDA MEDICAID
- ACCORDIA NATIONAL
- CAREPLUS HEALTH PLAN
- PIMA HEALTH PLAN
- MASSACHUSETTS MEDICAID / MASS HEALTH * <https://www.massrevs.eds.com>

Additional Enrollment Form Required with ORIGINAL Signature:

- BLUE CROSS BLUE SHIELD OF ALABAMA
- BLUE CROSS BLUE SHIELD OF ARIZONA
- BLUE CROSS BLUE SHIELD OF ARKANSAS
- VERMONT MEDICAID
- MEDICARE

Additional Enrollment Form Required with ORIGINAL Signature AND a Sample Letter on Physician Letterhead:

- BLUECROSS BLUESHIELD OF TEXAS - Must be accompanied by form "Sample Letter" on physician letterhead.

Notification to Emdeon Required:

- HealthNet California – Eligibility transaction
- Maine BCBS - Eligibility transaction.
- Michigan BCBS – Eligibility transaction
- Ohio BCBS – Eligibility transaction
- Virginia BCBS – Eligibility transaction
- Connecticut BCBS – Eligibility transaction

* This plan requires the end user to obtain an additional password directly from the payer.

Emdeon Office VAR – End User Setup Form

Customer Name:

Provider Information

Use additional lines per provider to add payer-specific Provider IDs for more than one payer. Payer-specific Provider IDs are most often required by government payers. They are not typically required for commercial payers.

Examples of payer-specific Provider IDs are Medicare ID#, Medicaid ID#, Blue Cross ID#, Commercial ID#, etc. If your Practice Management System does not assign a payer-specific provider ID in Box 33 or Box 24k (where applicable), Emdeon Office can assign the ID. Discuss this issue with your technician during the initial training process.

Please supply the following information:

	Provider Name	Provider Tax ID	Provider Specialty	Payer ID from Payer List	Payer-Specific Provider ID
Example	Wendy Provider	1111111111	Internal Medicine	12K46	11111111
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
11.					
12.					
13.					
14.					
15.					
16.					
17.					
18.					
19.					
20.					
21.					
22.					
23.					
24.					
25.					
26.					
27.					
28.					
29.					
30.					

Implementation Information

- Does the customer have prior experience with electronic billing? Yes
- Practice Management System Name/Company:
- File Format: Direct Data Entry Import – ANSI Import – Other: Print Image
- Office Hours/File Run information:
- Does the customer meet the minimum requirements for Office implementation? Yes
 - Pentium class PC
 - Color monitor - 800x600 minimum
 - Internet Explorer 6.0 or higher
 - Internet access
 - Minimum of 64 MB of RAM
 - Windows 2000, Windows NT, or Windows XP
 - Network connection or minimum 56.6 kbps modem



Electronic Patient Statements Enrollment Form REQUEST FOR SERVICES Patient Billing & Payment Solutions – Client Enrollment Form

Today's Date: 9/24/2008

Sales Representative: Alexia Moseley

Please fill out the information COMPLETELY and fax or mail it to the location listed below:

MediPro, Inc.
1301 Shiloh Road, Suite 1250
Kennesaw, GA 30144
Ph: 800.759.1321 Fax: 770.456.5049

FOR SALES USE ONLY	
Documents Signed: _____	Date Received: _____
<input type="checkbox"/> Postage Deposit	_____
<input type="checkbox"/> Contract	_____
<input type="checkbox"/> Business Associate Agreement	_____

General Information

New Client Existing Client **If Existing Client, list existing Accounts (Number, Name):** _____
Format Requested to Match Existing Account (Number, Name): _____

Client Demographic & Systems Information

Business Name: _____
Street Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Business Phone: _____ **Business Type:** Hospital Physician Office Dental Commercial Collections
Contact Name: _____ **Ext#:** _____ **In-House Tech Contact:** _____ **Ext#:** _____
File Confirmations go to: Fax Contact Name: _____ **Fax Number:** _____
 (1) Email Confirmation To: _____
 (2) Email Confirmation To: _____

Financial Information

Are you Tax Exempt? Yes No *If Yes, please include your tax exemption form with this enrollment*

Communication Information

Send Files by: BBS FTP Secure FTP/HTTP **Set-Up By:** Emdeon Business Services Software Vendor

Software Vendor/Channel Partner Information

Software Vendor / Channel Partner: _____ **Software:** _____
Contact Name: Marcus Zuckerman
Vendor Phone: 770-953-3546 **Ext#:** 113 **Email:** marcus@medipro.com

Product Selection

Desired Live Date: _____
 Emdeon ExpressBill Services (Print/Mail)
Print Facility: Toledo Scottsdale
NCOALink: Yes No **CASS Suppression:** Yes No
Foreign/Canadian Mail: Yes No
 Emdeon Patient Communications (Inserts)
I would like an explanation brochure inserted with my new statements: Yes *(Extra Charge will apply)* No

Layout & Processing Information

Product Type: Statements Invoices Letters Postcards (Catalog# _____) **Estimated Monthly Volume:** _____
Include Payment Due By Date: Yes No
If Yes, indicate # of days past statement date: _____ days

Paper Information

Papertype: Standard Custom **NOTE: A volume of 7,000 statements per month is required for custom paper**
If Custom, is a Sample Form Provided: Yes No
Custom Logo: Yes No **If Yes, Logo Format:** JPG EPS TIF *(High Resolution)*
Credit Cards Accepted: MASTERCARD VISA DISCOVER AMEX Other: _____ None
Duplexing: Yes No **Form Backprinting:** Standard Custom *(Enclose Sample)* None

For Office Use Only

PAPERTYPE: _____ **Billing Type:** Retail Wholesale Commercial **REGION:** _____
ACCOUNT NUMBER TYPE: 5 DIGIT BACKLINK **ACCOUNT NUMBER:** _____
USERNAME: _____ **PASSWORD:** _____

ERA Provider Setup Form – Only Complete if you are Requesting ERA

1	Receiver Information (Entity retrieving ERA file from Emdeon)												
Receiver					Contact								
Address													
City					State		Zip						
Telephone					Fax								
Email Address					Tax ID								
Emdeon ERA Product (Check only ONE)			<input type="checkbox"/> GTEDS TSO		<input type="checkbox"/> OKC Direct Log In ID		<input checked="" type="checkbox"/> Emdeon Office – NOT MEDICOMM Mail to: MP			<input type="checkbox"/> Other Login			
Format requested			<input type="checkbox"/> 4010 <input checked="" type="checkbox"/> 4010A		NOTE: You can only receive 1 (one) format for your files.								
Merge Group Required?			<input type="checkbox"/> Yes <input type="checkbox"/> No		Merge Group ID/Site ID/PBG#								
2	Vendor Information (Emdeon certified vendor used to retrieve ERA files from Emdeon)												
Vendor					Contact								
MediPro utilizing Emdeon Office as the vendor										Marcus Zuckerman			
Address										1301 Shiloh Road, Suite 1250			
City					State		Zip						
Kennesaw					GA		30144						
Telephone					Fax		770-953-3546					770-456-5049	
Email Address					marcus@medipro.com					MM# (for MMNS use only)			
Vendor/Submitter ID			223182772		<input type="checkbox"/> Clearinghouse <input type="checkbox"/> Direct <input type="checkbox"/> VNS (for Emdeon use only)								
3	Provider Information (Provider for whom ERA's will be returned to Emdeon)												
Group/Facility Name													
Provider Name					Provider Contact								
Provider Address													
City					State		Zip						
Provider Telephone					Provider Fax								
Provider E-mail Address													
Provider SSN/Tax ID (1 per form)													
PAYERS REQUESTED (see payer list at http://www.emdeon.com/PayerLists/payerlists.php) *GROUP ID/PROVIDER ID NOT REQUIRED FOR COMMERCIAL PAYERS. Payers requested <u>must</u> list ERA as a service on the Emdeon/ENVOY Payer List													
Payer Name			Emdeon Payer ID			Provider ID*			Group ID/Site ID*				
1													
2													
3													
4													
5													

Setup Notification to: Do Not Send Notification Vendor Billing Service/Dealer Facility/Provider
 Send Payer Forms (if requested) and Payer Approvals to: Vendor Billing Service/Dealer Facility/Provider

Pricing and Payment Options

Initial Fees:

Setup Fee for Lytec PMS: \$175.00
Setup Fee for Other PMS: \$225.00
Setup Fee for Direct Claim Entry: \$325.00

Electronic Claims Option (check only one):

Electronic Claims, Eligibility, Authorizations, and Referrals - # of Provider(s) _____

Electronic Claims, ERA, Eligibility, Authorizations, and Referrals - # of Provider(s) _____

Please note that once you enroll in ERA, you will be charged for all ERA files whether you use them or not.

Your software must support the ERA ANSI format 837. _____ (please initial)

Important: Paper claims are processed at \$0.44 per claim. It is the customer's responsibility to control if paper claims are to be printed and mailed by Emdeon. If a claim is sent to Emdeon, Emdeon will process the claim regardless if it is a paper or electronic claim. If you do not want paper claims processed, you must not send them to Emdeon. MediPro will instruct the customer on how to distinguish between paper and electronic claims in your practice management system. _____ (please initial)

Optional Services:

Electronic Patient Statements – \$0.62 per statement / \$0.27 additional statement pages.

***Please note that multi-page statements may require additional postage and will be charged to your account.**

Direct Claim Entry - \$10.00 per month per provider in additional to the standard charge.

Initial Setup Fee to be Charged is:	\$ _____	
Claims Processing Deposit:	\$ _____	(1 month payment in advance)
Patient Statement Deposit:	\$ _____	(Number of monthly statements x \$0.62)
Total initial fee to be charged is:	\$ _____	

Email address to receive monthly statements: _____

Payment Options and Authorization

OPTION I: Payment by credit card

Customer hereby authorizes MediPro to initiate charges to the credit card account indicated below. Customer agrees to provide at all times current and accurate credit card information. Customer shall provide replacement information, in writing, within 30 days of change directly to MediPro (MediPro, Inc.; Attention: Accounts Receivable; 1301 Shiloh Road, Suite 1250, Kennesaw, GA 30144 or via fax to 770.456.5049).

This authority is to remain in full force and effect until MediPro has received written notification from me of termination of this authorization in such time and in such manner as to afford MediPro a reasonable opportunity to act on it. I have the right to stop payment of a credit card charge by written notification to MediPro, and provision of acceptable replacement payment information, at such time as to afford MediPro a reasonable opportunity to act on it prior to charging my credit card account. This agreement is subject to all terms and conditions shown above. I agree to pay the above total according to the terms and conditions of the card issue agreement.

Undersigned hereby agrees and authorizes MediPro, Inc. to keep my signature on file and to charge the credit card account identified below for all amounts associated with electronic claims and/or statements processing.

Visa **MasterCard** **American Express** **Discover**

Acct. #: _____ Exp Date. _____

Name on Card: _____

Billing Address & Zip Code: _____

OPTION II: Electronic Funds Transfer (EFT) – Please attach a voided check below

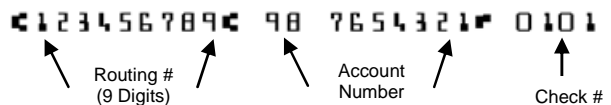
Customer hereby authorizes MediPro to initiate debit entries to the checking account indicated below and the depository named below (“Depository”) to debit the same to such account. Customer agrees to provide at all times current and accurate ACH information. Customer shall provide replacement information, in writing, within 30 days of change directly to MediPro (MediPro, Inc.; Attention: Accounts Receivable; 1301 Shiloh Road, Suite 1250, Kennesaw, GA 30144 or via fax to 770.456.5049).

This authority is to remain in full force and effect until MediPro and Depository has received written notification from me of termination of this authorization in such time and in such manner as to afford MediPro and Depository a reasonable opportunity to act on it. I have the right to stop payment of a debit entry by written notification to MediPro and Depository, and provision of acceptable replacement payment information, at such time as to afford MediPro and Depository a reasonable opportunity to act on it prior to charging my account. After the account has been charged, I have the right to have the amount of the erroneous debit immediately credited to my account by Depository provided I send written notice of such debit entry in error to MediPro and Depository within 15 days following the issuance of the account statement or 45 days after posting, whichever occurs first. This agreement is subject to all terms and conditions shown above.

Depository: _____

Routing Number: _____

Checking Account Number: _____



The initial fee will be charged to your account upon receipt of this registration form. The claims processing deposit will be applied to your account upon termination of your service. I understand that I will be responsible for paying for all payer pass-through charges for any services processed through Emdeon. I also understand that these fees and payers listed may change without notice. Please see the next page for a list of payers with payer pass-through charges.

Billing Cycle and Charges

Billing cycles are posted on the 15th of each month for the prior month's claims processing. The initial fee charged includes the following:

I hereby select **payment option** _____ as shown above and accept all terms and conditions attached thereto in accordance with normal policy.

The initial fee is non-refundable

Account Holder Signature: _____ **Date:** _____

Eligibility Payer Pass-through Charges

The following eligibility charges are imposed by the specific payer listed below. You will be responsible for paying all fees for services processed through Emdeon.

Payer	Transaction Charge	Payer	Transaction Charge
ACCESS MEDPLUS	0.05	MCARE OHIO	0.03
BLUE CROSS OF MISSISSIPPI	0.05	MEDICARE - PART A	0.03
BLUE CROSS OF MISSISSIPPI CHILD	0.05	MEMORIAL CARE TPA	0.18
BLUE CROSS/SHILED OF CT	0.10	MINNESOTA MEDICAID	0.05
BLUE CROSS/SHILED OF ME	0.10	MISSISSIPPI MEDICAID	0.03
BLUE CROSS/SHILED OF MI	0.10	MISSOURI MEDICAID	0.07
BLUE CROSS/SHILED OF OH	0.10	MOMAHA	0.04
BLUE CROSS/SHILED OF VA	0.10	MS STATE EMPLOYEES	0.05
BLUE SHIELD OF CA	0.18	NEW MEXICO MEDICAID	0.03
COLORADO MEDICAID	0.03	NORTH CAROLINA MEDICAID	0.03
CONNECTICUT MEDICAID	0.03	OHIO MEDICAID	0.03
FLORIDA MEDICAID	0.03	OKLAHOMA MEDICAID	0.02
FLORIDA MEDICARE	0.03	PARTNERSHIP HEALTH PLAN OF CA	0.18
GEORGIA MEDICAID	0.03	SAN FRANCISCO HEALTH PLAN	0.18
HARVARD PILGRIM HEALTHCARE	0.10	SAN JOAQUIN HEALTH PLAN	0.18
HEALTH NET MEDI-CAL	0.18	SENIOR CARE ACTION NETWORK (SCAN) HMO	0.18
HEALTH NET OF CALIFORNIA	0.18	SOUTH DAKOTA MEDICAID	0.03
HEALTH NET OF OREGON	0.18	STANISLAUS COUNTY MIA PROGRAM	0.18
ILLINOIS MEDICAID	0.02	TENNESSEE MEDICAID	0.04
INLAND EMPIRE HEALTH	0.18	TEXAS MEDICAID	0.08
INTER VALLEY HEALTH PLAN	0.18	UNIVERSAL CARE OF CALIFORNIA	0.18
IOWA MEDICAID	0.08	WASHINGTON MEDICAID	0.03
MCARE GEORGIA BCBS	0.03	WESTERN HEALTH ADVANTAGE	0.18
MCARE ILLINOIS	0.03	WISCONSIN MEDICAID	0.05
MCARE INDIANA	0.03	WYOMING MEDICAID	0.03
MCARE KENTUCKY	0.03		
MCARE NEW YORK EMPIRE BCBS	0.03		

Terms and Conditions

This agreement is made by and between MediPro, Inc. (hereinafter referred to as MediPro) and the customer (hereinafter referred to as Customer).

TERMS AND TERMINATION:

1. This agreement has no specific termination date and will remain in effect as long as the Customer is utilizing the services of Emdeon and MediPro.
2. This Agreement shall become effective the date accepted, in writing, by both MediPro and the Customer.
3. Either party may terminate this Agreement at any time with a thirty (30) day written notice of cancellation.
4. Any deposits made on the account will be returned to the Customer when all outstanding invoices are paid in full.

INSTALLATION AND SUPPORT:

1. Customer has 90 days to submit a test file from the date the enrollment paperwork is received. Failure to do so may result in a \$175.00 reactivation fee.
2. MediPro will provide assistance with installing the required software for the Customer's electronic submissions.
3. MediPro will provide the initial training for the required software and electronic submission process.
4. This agreement will provide the Customer with support limited to the electronic submission process and software. It does not provide the Customer with support on the Customer's practice management system, unless you have a current support contract with us.
5. Support questions are handled by phone, email or fax.
6. Every attempt will be made to resolve all support questions in a reasonable time. However, under certain circumstances additional response time may be required to answer the question fully, and may involve you providing more information to us. The response time will be affected by the complexity of the question and our ability to reproduce any errors you may be experiencing.
7. MediPro makes no warranties that a satisfactory resolution will be provided to the Customer's support question. However, MediPro does warrant that the very best resources will be made available in an attempt to provide a resolution.
8. MediPro may charge a fee if the Customer requires further training after transmitting claims and/or statements for more than thirty (30) days.

CHARGES:

1. MediPro will base the charges for insurance claims processing and other services upon a one-time initial fee, payable upon receipt of this registration form and all fees set forth according to the pricing options and services requested will be billed as such fees are incurred.
2. MediPro reserves the right to increase or decrease fees upon submission of thirty (30) days written notice to the Customer.
3. Charges will be debited from the Customer's chosen method of payment between the 15th and 20th of every month for the previous months billings.

EFT:

1. Automatic payments will be debited from the Customer's bank account between the 15th and 20th of every month for the previous months billing.
2. Should the Customer desire to place a "stop payment order" on any future debit, Customer may do so by giving MediPro notice in writing at least three (3) business days before payment is due. The Customer must then supply an alternative method of payment and all outstanding invoices must be paid in full.

RETURNED PAYMENT:

1. Customer agrees to pay MediPro a fee of \$20.00 for each returned payment from the Customer's selected method of payment. These include but are not limited to returned checks, charge backs (electronic funds transfers), and credit card denials.
2. It is the Customer's responsibility to notify MediPro of any changes including, but not limited to the following:
 - a. Credit card expiration dates
 - b. Credit card account numbers
 - c. Bank account numbers

OUTSTANDING BALANCES:

1. In the event that MediPro is unsuccessful in debiting charges from the Customer's chosen method of payment, the Customer will be notified and payment must be made in full within ten (10) business days.
2. In the event that payment is not received within the given timeframe, MediPro may, in addition to any other right or remedy which it may have under this agreement or at law, terminate this Agreement and Customer's use of the services. The Customer may be subject to a \$175.00 reactivation fee if the service is cancelled due to non payment.
3. Invoices unpaid after thirty (30) days of the invoice date shall be subject to a service charge of \$5.00 per month or 12% interest per annum, whichever is greater.
4. Customer agrees to reimburse MediPro for all costs and expenses, including, but not limited to reasonable attorney's fees and all costs and fees of collection incurred in enforcing MediPro's rights or remedies.

CANCELLATION:

1. This agreement may be cancelled by the Customer at any time by mailing or faxing a notice of cancellation to MediPro. **Emdeon will not be responsible for handling cancellation requests.**
2. Cancellation will go into effect the month following receipt of the cancellation notice.
3. The Customer is responsible for all monies due including the current month that the cancellation notice is received.

LIMITATION OF LIABILITY:

1. In no event will MediPro be held liable for any indirect, incidental or consequential damages, even if MediPro has been advised of the possibility of such damages.
2. In no event shall MediPro be liable for loss or damages resulting directly or indirectly, in whole or in part, from errors, omissions, insolvency or other circumstance attributable to any insurance carrier.

Authorized Signature: _____

Date: _____

Emdeon Support

Please retain this page for future reference

It is very important that you contact MediPro at 800.759.1321 x 2 for all Emdeon related inquires. Please do not contact Emdeon directly for any support, enrollment or paperwork questions.

Emdeon Support – 800.759.1321 x 2