



220 Burnham Street • South Windsor, CT 06074
 Vox 888-255-7293 • Fax 860-289-0055

**DESERET MUTUAL BENEFIT ADMINISTRATORS
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CX089				
ELECTRONIC REGISTRATIONS Agreements Required	<p>Emdeon Provider Enrollment Form</p> <ul style="list-style-type: none"> • Please complete all requested information. <p>Electronic Billing Enrollment Form</p> <ul style="list-style-type: none"> • Please visit http://www.dmba.com/provider/Default.aspx to complete the Electronic Billing Enrollment Form. • Information needed to complete the Electronic Billing Enrollment Form. <ol style="list-style-type: none"> Utah Trading Partner Number: HT001755-022 *E-mail: dentalsupport@emdeon.com Check the box for 'Dental Claims (ADA 2006/J400) • Print the Electronic Billing Enrollment Form and fax or mail along with the Emdeon Provider Enrollment Form to the below address. 				
SEND REGISTRATION FORMS TO	<p align="center">Emdeon 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Or Fax to: 860-289-0055</p>				
ENROLLMENT CONFIRMATION	<p>Enrollment will be coordinated between Deseret Mutual Benefit Administrators and Emdeon. Once approval is received Emdeon will notify the provider or their software vendor.</p>				
CHANGING ELECTRONIC BILLING AGENTS	<p>If the Provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.</p>				
CONTACT PHONE NUMBERS	<table border="0"> <tr> <td>DMBA Provider Maintenance</td> <td align="right">800-777-3622</td> </tr> <tr> <td>Emdeon Provider Enrollment</td> <td align="right">888-255-7293, option 1</td> </tr> </table>	DMBA Provider Maintenance	800-777-3622	Emdeon Provider Enrollment	888-255-7293, option 1
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Deseret Mutual Benefit Administrators – payer ID CX089**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(Number that will be used to submit electronic claims)

Software Vendor: _____

Group NPI: _____
(if applicable)

Name	Rendering	NPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Rendering Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____