



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

**ALABAMA MEDICAID  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CKAL1</b>						
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<b>Emdeon Business Services Provider Enrollment Form</b> <ul style="list-style-type: none"> <li>• Please complete all requested information</li> </ul>						
<b>SEND REGISTRATION FORMS TO:</b>	Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Or Fax to: 860-289-0055						
<b>ENROLLMENT CONFIRMATION</b>	Emdeon Business Services will verify the provider's status with Alabama Medicaid. Once the providers status is obtained Emdeon Business Services will notify either the provider or their software vendor.						
<b>CHANGING ELECTRONIC BILLING AGENTS</b>	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.						
<b>CONTACT PHONE NUMBERS</b>	<table> <tr> <td>Medicaid In-State Providers</td> <td align="right">800-688-7989</td> </tr> <tr> <td>Medicaid Out-of-State Providers</td> <td align="right">334-215-0111</td> </tr> <tr> <td>Emdeon Business Services</td> <td align="right">888-255-7293</td> </tr> </table>	Medicaid In-State Providers	800-688-7989	Medicaid Out-of-State Providers	334-215-0111	Emdeon Business Services	888-255-7293
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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **ALABAMA MEDICAID**

Provider/Organization Name: \_\_\_\_\_  
*(As registered with Alabama Medicaid)*

Tax Identification or Social Security Number: \_\_\_\_\_  
*(This is the number that will be used to submit electronic claims)*

Software Vendor: \_\_\_\_\_

Group Number: \_\_\_\_\_  
*(if applicable)*

Group NPI Number: \_\_\_\_\_  
*(if applicable)*

Rendering  
*(As registered with Alabama Medicaid)*

Name	Number	NPI
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Date: \_\_\_\_\_