



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

**CARESOURCE  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CKOH2</b>				
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<p><b>*PLEASE NOTE ENROLLMENT IS NOT REQUIRED FOR CARESOURCE. IF A PROVIDER WISHES TO SUBMIT CLAIMS ELECTRONICALLY, THEY NEED TO ENSURE THEIR 12 DIGIT CARESOURCE PROVIDER ID IS SENT IN THE PROPER FIELD OF THEIR CLAIMS.</b></p> <p><b>Emdeon Business Services Provider Enrollment Form</b></p> <ul style="list-style-type: none"> <li>• Please complete all requested information if you do not have the ability to send your Caresource provider ID within your claims.</li> </ul>				
<b>SEND REGISTRATION FORMS TO</b>	<p align="center">Emdeon Business Services          220 Burnham Street          South Windsor, CT 06074          Attn: Provider Enrollment          Or          Fax to: 860-289-0055</p>				
<b>CONFIRMATION</b>	<p>Once the 12 digit Caresource provider number has been added to our system, Emdeon will notify the provider or their software vendor.</p>				
<b>CONTACT PHONE NUMBERS</b>	<table border="0"> <tr> <td>Caresource</td> <td align="right">800-488-0134</td> </tr> <tr> <td>Emdeon Business Services</td> <td align="right">888-255-7293</td> </tr> </table>	Caresource	800-488-0134	Emdeon Business Services	888-255-7293
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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **CARESOURCE - PAYER ID# CKOH2**

Provider/Organization Name: \_\_\_\_\_

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

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

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

Name	Rendering	Number
_____	-	_____
_____	-	_____
_____	-	_____
_____	-	_____

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

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

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

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

Signature: \_\_\_\_\_ 

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