

**CONNECTICUT MEDICAID  
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

<b>PAYER ID NUMBER</b>	<b>CKCT1</b>				
<b>ELECTRONIC REGISTRATIONS</b>  Agreements Required	<b>EMDEON BUSINESS SERVICES PROVIDER ENROLLMENT FORM</b> <ul style="list-style-type: none"> <li>• Please supply all required information</li> </ul>				
<b>SPECIAL NOTES</b>	<ul style="list-style-type: none"> <li>▪ Since September of 1995, EDS is no longer the sole administrator of Medicaid claims for the state of Connecticut. All claims destined specifically for EDS of Connecticut require that the provider complete the registration process as above.</li> </ul>				
<b>SEND REGISTRATION FORMS TO:</b>	Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment  Fax # 860-289-0055				
<b>ENROLLMENT CONFIRMATION</b>	Emdeon Business Services will coordinate enrollment with EDS and notify the provider or their software vendor when approval is received.				
<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 border="0"> <tr> <td>EDS Medicaid of CT</td> <td align="right">860-409-4500</td> </tr> <tr> <td>Emdeon Business Services</td> <td align="right">888-255-7293</td> </tr> </table>	EDS Medicaid of CT	860-409-4500	Emdeon Business Services	888-255-7293
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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Connecticut Medicaid – payer ID CKCT1**

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

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

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

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

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

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

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

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

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

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

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