



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

**DELAWARE MEDICAID
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKDE1
ELECTRONIC REGISTRATIONS Agreements Required	ECS Provider Agreement <ul style="list-style-type: none"> ▪ Fill in the following: <ul style="list-style-type: none"> ▪ SECTION I <ul style="list-style-type: none"> ▪ Provider's Name ▪ SECTION II <ul style="list-style-type: none"> ▪ Provider's Name ▪ Street Address ▪ City, State & Zip Code ▪ Delaware Medicaid Provider Number & Provider Name ▪ SECTION III <ul style="list-style-type: none"> ▪ Provider's Signature ▪ Provider's Name typed or printed Emdeon Business Services Provider Enrollment Form <ul style="list-style-type: none"> • Please complete all requested information.
SPECIAL NOTES	<ul style="list-style-type: none"> ▪ Medicaid will only allow original signatures on the ECS Provider Certification Agreement. Copies or facsimiles of the form will not be accepted by Delaware Medicaid. ▪ Do NOT mail these forms back to Delaware Medicaid. Original Signature of Billing Agent is required. Send it to the address under "SEND REGISTRATION FORMS TO:" on this instruction sheet.
SEND REGISTRATION FORMS TO:	<p align="center">Please mail completed ORIGINALS to:</p> <p align="center">Emdeon Business Services. Attn: Provider Registration 220 Burnham Street South Windsor, CT 06074</p>



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ENROLLMENT CONFIRMATION	Once Medicaid approves electronic claims submission, Emdeon Business Services will notify the provider or their software vendor.				
CHANGING ELECTRONIC BILLING AGENTS	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.				
CONTACT PHONE NUMBERS	<table> <tr> <td>Delaware Medicaid</td> <td>302-454-7154</td> </tr> <tr> <td>Emdeon Business Services</td> <td>888-255-7293</td> </tr> </table>	Delaware Medicaid	302-454-7154	Emdeon Business Services	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Delaware Medicaid – payer ID CKDE1**

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: _____

**DELAWARE TITLE XIX
ELECTRONIC CLAIM SUBMISSION
PROVIDER CERTIFICATION AGREEMENT**

EDS has developed, under the State of Delaware Medicaid Program, a paperless claim processing system that will process Delaware Medicaid claims submitted through various designated electronic media in lieu of claims submitted on paper forms.

SECTION I

_____ Hereinafter referred to as “Provider” hereby
(Provider Name) certifies as follows:

1. The Department of Health and Social Services (DHSS) shall allow Providers to prepare and submit Medicaid claims through the use of magnetic tapes, diskettes, modem transmission, and other electronic media designated by EDS, hereinafter referred to as “Electronic Media”, developed by themselves or by authorized computer vendors in conformance with the current EDS paperless claim specifications and any revisions that may occur from time to time.
2. The Provider understands that this Certification is made by and between the State of Delaware (DHSS), through EDS, and the aforementioned Provider.
3. The Provider understands that to become certified, the Provider must complete, to the satisfaction of EDS, a successful testing period, which may consist of more than one test.
4. Certification must be executed for each provider number that the Provider represents prior to claim submission for that Provider. All electronic claims received by EDS for provider numbers not certified will not be processed.
5. The Provider certifies that all services for which reimbursement will be claimed shall be provided in accordance with all federal and state laws pertaining to the Delaware Medicaid Program, and that all charges submitted for services and items provided shall not exceed Provider’s usual and customary charges for the same services and items provided to persons not entitled to receive benefits under the Delaware Medicaid Program.
6. The Provider understands that any payments made in satisfaction of claims submitted through Electronic Media will be delivered from federal and state funds and that any false claims, statements or documents, or concealments of a material fact may be subject to prosecution under federal and state law.

SECTION I – continued

7. The Provider shall allow EDS access to claims data and assures that claims data will be submitted by authorized personnel so as to preclude erroneous payments received by Provider regardless of the reason for such erroneous payments.
8. If EDS determines that the submission of Electronic Media Claims fails to comply fully with the paperless claims specifications then in effect or any guidelines governing the submission of electronic media claims, or if EDS judges such electronic media to contain an unreasonable number of errors, then EDS may, with the approval of DHSS, terminate this Certification five (5) work days after the Provider has received a written notice from EDS.
9. The Provider understands that all other terms and conditions of participation in the Delaware Title XIX Program remain in effect and unchanged by this Certification.
10. EDS, as the Fiscal Agent for the Delaware Medicaid Program, has been granted the authority by DHSS to approve Providers who wish to submit claims electronically.
11. In the event a billing service is used, the Provider here by certifies that

CLAIMS PROCESSING SERVICE, INC.

220 BURNHAM STREET, SOUTH WINDSOR, CT 06074

(Billing Service Name and Address)

is authorized to submit claims on the Provider's behalf using Electronic Media. The Provider agrees that if the billing agreement with the aforementioned billing service is terminated, the Provider will immediately report the termination in writing to EDS. The Provider must complete a new Certification upon making a change from one Billing Service to another.

SECTION II

Please print or type the following information:

Provider Name: _____

Provider Address: _____

City, State, Zip: _____

Please list the Medicaid provider numbers and names for which you will be submitting electronic claims:

	Medicaid Provider Number	Medicaid Provider Name
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____
7.	_____	_____
8.	_____	_____
9.	_____	_____
10.	_____	_____
11.	_____	_____
12.	_____	_____
13.	_____	_____
14.	_____	_____
15.	_____	_____

SECTION III

AUTHORIZATION TO SUBMIT ELECTRONIC CLAIMS

PROVIDER

I hereby certify that I have examined this agreement and that the representations that are contained in this agreement are true and correct. I hereby authorize the below stated individuals to submit electronic claims on my behalf to the State of Delaware Medicaid Program. I agree to notify Medicaid, in writing, of any changes to this agreement.

Signature of Provider: _____

Printed: _____

PERSONS AUTHORIZED TO SUBMIT CLAIMS ELECTRONICALLY

I accept responsibility for the accuracy of the electronic claims submitted to Medicaid, and understand that a confidential identification number will be assigned for my use only. I understand that the failure to maintain the confidentiality of my identification number resulting in falsified claims may lead to criminal prosecution.

Signature: _____

Printed: _____

Signature: _____

Printed: _____

Signature: _____

Printed: _____

Signature: _____

Printed: _____

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

Approved By: _____ Date: _____