



emdeon™

business services

220 Burnham Street • South Windsor CT 06074

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**IDAHO MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKID1
ELECTRONIC REGISTRATIONS Agreements Required	Electronic Claims Submission Certification and Authorization <ul style="list-style-type: none"> ▪ Fill in the Provider's name ▪ SECTION I: <ul style="list-style-type: none"> ▪ Fill in Provider name, address, phone number, Medicaid Group Number, Medicaid Individual Provider numbers. ▪ Sign & Date ▪ SECTION II: <ul style="list-style-type: none"> ▪ No information needs to be filled in. Already provided. Emdeon Business Services Provider Enrollment Form <ul style="list-style-type: none"> • Please complete all requested information.
SEND REGISTRATION FORMS TO:	Please mail completed forms to: Emdeon Business Services 220 Burnham Street South Windsor, CT 06074
ENROLLMENT CONFIRMATION	<ul style="list-style-type: none"> ▪ Enrollment will be coordinated between Emdeon Business Services and EDS. Once approval has been received 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 the Provider must re-enroll following the procedures outlined above.
CONTACT PHONE NUMBERS	EDS Provider Enrollment In-state: 208-383-4310 EDS Provider Enrollment Out-of-state: 800-685-3757 Emdeon Business Services: 888-255-7293



PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Idaho Medicaid – payer ID CKID1**

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)

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

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Idaho Medicaid Program

Electronic Claims Submission Certification and Authorization

_____, hereinafter referred to as 'Provider', hereby certifies as follows:
(Provider name)

The Provider certifies that all services and items for which reimbursement will be claimed shall be furnished by, or under the supervision of, the Provider.

The Provider understands that use of electronic claims submission does in no way relieve the provider of responsibilities for maintaining (a) such medical and fiscal records as are necessary to disclose fully the nature and extent of services or items provided by the Provider to Medicaid recipients, and making such records available upon request to the Department of Health and Welfare and the United States Department of Health and Human Services; and (b) promptly returning to the Department of Health and Welfare, or its fiscal agent, the amount of any erroneous or excess payments received for services or items provided to any Medicaid recipients.

The Provider certifies that the claim is due; that the Provider is authorized to sign for the payee; that complete records of these services are being kept for three (3) years and will be provided upon request. The Provider accepts payment in full for the claims submitted subject to adjustment as authorized by Department Regulations and that these services have been rendered without unlawful discrimination on the grounds of race, age, sex, creed, color, national origin, or physical or mental handicap. Provider certifies that if prescription services are provided, a legal prescription is on file for each medication issued.

The Provider certifies that all services and items from which reimbursement will be claimed shall be provided in accordance with all federal and state laws pertaining to the Idaho 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 when provided to persons not entitled to receive benefits under the Idaho Medicaid Program.

The Provider understands that any payments made in satisfaction of claims submitted will be derived from Federal and State funds and that any false claims, statements or documents, or concealment of material fact may be subject to prosecution under applicable Federal and State law.

If the Provider uses a billing service, the Provider agrees to report completely and accurately to the billing service all information necessary to ensure compliance with federal and state laws pertaining to the Idaho Medicaid Program, as amended.

The Provider understands that the Department reserves the right to revoke its approval for electronic claims submission, at any time, for failure on the part of the Provider or billing service to comply fully with any or all guidelines governing the submission of electronic claims.

The Provider holds EDS harmless and indemnifies EDS against any liability to the Provider, the State of Idaho or to any Medicaid Provider arising out of the entering into this agreement or subsequent receiving and processing of Medicaid claims by tape or other electronic media.

SECTION I

1. DHW shall allow Providers to enter Medicaid claims through the claims entry system developed by the Department's fiscal agent and designated 'ECS', Electronic Claims Submission, or through the use of entry screens developed by authorized computer vendors, or by magnetic tape.
2. Both EDS and the State of Idaho must approve of any provider **prior** to the submission of electronic claims.
3. The Provider shall allow the Department access to claims data and assure that submission of claims data is restricted to authorized personnel so as to preclude erroneous payments resulting from carelessness or fraud.
4. The provider understands that the ECS diskette developed by EDS is considered the property of the originator and may not be altered in any way.

Provider Name: _____

Provider Address: _____

Phone Number: _____

Group Provider Number: _____

Individual Provider Number(s): _____

Authorizing Signature: _____ Date: _____

SECTION II

(To Be Completed By Providers Using a Billing Service)

The Provider agrees to abide by the policies affecting electronic submissions as published in the electronic specification manual for Medicaid claims.

The Provider hereby certifies that Claims Processing Service, Inc. is authorized to submit electronic
(Billing Service)

claims on Provider's behalf. **The Provider agrees that if the billing arrangement with the aforementioned billing service is terminated, the Provider will immediately report the termination in writing to the Department or its fiscal agent.**

After completing this form, please return to:

**Electronic Data Systems
Provider Relations
Attention: EDI Coordinator
P.O. Box 23
Boise, ID 83707**