

**MARYLAND MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKMD1
ELECTRONIC REGISTRATIONS Agreements Required	TRADING PARTNER AGREEMENT <ul style="list-style-type: none"> • Pg 1: Fill in provider name and address. • Pg 2: Fill in provider name, provider number, provider signature and date SUBMITTER IDENTIFICATION FORM <ul style="list-style-type: none"> • Sec 1: Choose New Application or Change of Submitter Agent • Sec 2: Fill in provider name, address, provider number and NPI number. • Sec 4: Fill in provider name, provider signature, provider name, telephone number and date. EMDEON BUSINESS SERVICES PROVIDER ENROLLMENT FORM <ul style="list-style-type: none"> • Please complete all required information
SPECIAL NOTES	<ul style="list-style-type: none"> ▪ Maryland Medicaid will only allow original signatures. Please make a copy for your records. ▪ Effective 3-29-07 Maryland Medicaid requires the National Provider Identifier (NPI) be included on all enrollment requests.
SEND REGISTRATION FORMS TO:	Please mail <u>ORIGINAL</u> completed forms to: Emdeon Business Services Attn: Provider Registration 220 Burnham Street South Windsor, CT 06074
ENROLLMENT CONFIRMATION	Enrollment will be coordinated between Maryland Medicaid and Emdeon Business Services. Emdeon will notify the provider or their software vendor when an approval is received.



emdeon™

business services

220 Burnham Street • South Windsor, CT 06074

Vox 888-255-7293 • Fax 860-289-0055

CHANGING ELECTRONIC BILLING AGENTS	If the provider currently submits claims through another Billing Agent other than Emdeon Business Services each Provider must complete new enrollment forms. When completing the Maryland Medical Care Programs Submitter Identification Form select Change of Submitter Agent not New Application.				
CONTACT PHONE NUMBERS	<table><tr><td>Medicaid Provider Relations</td><td>410-767-6940</td></tr><tr><td>Emdeon Business Services</td><td>888-255-7293</td></tr></table>	Medicaid Provider Relations	410-767-6940	Emdeon Business Services	888-255-7293
Medicaid Provider Relations	410-767-6940				
Emdeon Business Services	888-255-7293				



PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Maryland Medicaid – payer ID CKMD1**

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: _____

standards, the trading partners agree to incorporate by reference any modifications or changes to 45 CFR Part 162.

6. Prohibited Acts- 45CFR § 162.915 specifies that trading partners will not enter into an agreement that would: “change the definition, data condition or use of a data element or segment in a standard; add any data elements or segments to the maximum defined set; use any code or data elements that are either marked “not used” in the standard’s implementation specification or are not in the standard’s implementation specifications(s); or change the meaning or intent of the standard’s implementations specification(s)”.
7. Expenses- Each party shall bear its own expenses in implementing this process of transmitting information via this agreement.
8. Confidentiality and Security- Each party shall comply with all HIPAA and State Security and Confidentiality requirements in the handling of protected health information and take reasonable precautions to prevent unauthorized access to any part of the transaction process. In the event that data is improperly sent or received under this agreement, such data shall be highlighted and disposed of or returned in an appropriate manner.
9. Provider Identifiers- The parties shall agree on a unique identifier to be used by Provider. Provider is responsible for disclosing the unique identifier to its agents and only as is prudent to maintain appropriate security for the identifier.
10. This Trading Partner Agreement may be terminated by the Medical Care Program at any time.

All other agreements between the Program and Provider remain in full force and effect.

AGREED:

PROVIDER NAME: _____

PROVIDER NUMBER: _____

AUTHORIZED SIGNATURE

DATE: _____



RETURN VIA MAIL:

Rita Tate
201 W. Preston St., Rm. LL 3
Baltimore, MD 21201
ATTN: HIPAA Billing Agreements

**MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM**

Maryland Medicaid needs some EDI information to exchange HIPAA transactions with you. Please provide the information below. If you are not processing your own EDI transactions, please have your Electronic Submitter assist you in completing this form, specifically with items #3 and #4.

1. This is a Select Media if New Application:
 New Application Electronic Transfer & Paper Voucher
 Change of Submitter Agent Paper Voucher Only
 Submitter Identification Form Update

2. Provider Information

a) Provider Name:	
b) Provider Address:	
c) Provider Number (must be 9 digits):	
d) National Provider Identifier (NPI #)	

3. Electronic Submitter Information

a) Submitter Name:	CPS / WebMD Dental dba Emdeon Business Services
b) Submitter Address:	220 Burnham Street, South Windsor, CT 06074
c) Submitter ID(ISA Qualifier and ISA ID):	EC0496

4. EDI Information

Please select the transactions that you want to exchange with Maryland Medicaid out of the following transactions:

CHECK	TRANSACTIONS	VERSION
	270/271 Eligibility Inquiry & Response	004010X092A1
	276/277 Claim Status & Response	004010X093A1
	837 Health Care Claim Institutional	004010X096A1
	837 Health Care Claim Professional	004010X098A1
	837 Health Care Claim Dental	004010X097A1
	820 Premium Payment	004010X061A1
	835 Health Care Claim Payment/Advice 835 GS Receiver ID (Required, if Checked)	004010X091A1
	Receiver EDI Information received in different from above listed Submitter ID or if you are Pharmacy Provider Business Associate requesting (35) Receiver Name: Receiver Address: ISA Qualifier and ISA ID:	



MARYLAND MEDICAL CARE PROGRAMS
SUBMITTER IDENTIFICATION FORM

The provider, _____ hereby authorizes

PROVIDER NAME

CPS/WebMD Dental dba Emdeon Business Services, hereafter

SUBMITTER AGENT

referred to as Submitter Agent, to transmit our Medicaid claims to Maryland Medical Care Program, and further authorizes Maryland Medical Care Program to transmit to the Submitter Agent the return computer file electronic vouchers of all claims data processed, indicating paid, rejected, denied and pended claims (with error codes). The Submitter Agent agrees to protect the confidentiality of this data as required by law.



Signature of Provider

Signature of Submitter Agent

Print Name of Signature

Dawn L Vaughan

Print Name of Signature

Telephone Number **Date**

860-289-6090

Telephone Number **Date**

Note: This form requires completion of all requested information and **original signatures** to be processed.

MAIL TO:

SYSTEM LIAISON SERVICES
201 WEST ST, RM SS-18
BALTIMORE, MD 21201
ATTN: HIPAA DESK



For Internal Use Only:

Systems Liaison Services Signature: _____

Date Received: _____