



emdeon™

business services

220 Burnham Street • South Windsor, CT 06074

Vox 888-255-7293 • Fax 860-289-0055

**MAINE MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

| | | | | | |
|--|--|--------------------|--------------|--------------------------|--------------|
| PAYER ID NUMBER | CKME1 | | | | |
| ELECTRONIC REGISTRATIONS Agreements Required | <p>Emdeon Business Services Provider Enrollment Form</p> <ul style="list-style-type: none"> ▪ Please complete all requested information. <p>MaineCare Electronic Media Claims Rider</p> <ul style="list-style-type: none"> • Sec. C: Please supply Provider’s signature, date, provider’s name, title, office name, billing provider ID, and office phone number. | | | | |
| SEND REGISTRATION FORMS TO: | <p align="center">Please mail or fax to:</p> <p align="center">Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment</p> <p align="center">Fax #: 860-289-0055</p> | | | | |
| ENROLLMENT CONFIRMATION | <ul style="list-style-type: none"> ▪ Enrollment will be coordinated between Maine Medicaid and Emdeon Business Services. Emdeon will notify the provider’s software company or the provider upon completion. | | | | |
| CHANGING ELECTRONIC BILLING AGENTS | <p>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.</p> | | | | |
| CONTACT PHONE NUMBERS | <table> <tr> <td>Provider File Unit</td> <td align="right">800-321-5577</td> </tr> <tr> <td>Emdeon Business Services</td> <td align="right">888-255-7293</td> </tr> </table> | Provider File Unit | 800-321-5577 | Emdeon Business Services | 888-255-7293 |
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| Emdeon Business Services | 888-255-7293 | | | | |



PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Maine Medicaid – payer ID CKME1**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(This is the 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: _____

MAINECARE
ELECTRONIC MEDIA CLAIMS RIDER

This Rider permits the electronic generation of claims that will be acceptable to the Department in lieu of written claims. This Rider sets forth requirements under which the provider and the Department will operate:

- Section A: Responsibilities of the Provider
- Section B: Responsibilities of the Department
- Section C: Ratification

Section A

Responsibilities of the Provider

1. The Provider agrees to submit claims to the Department only in the format specified by the Department.
2. The Provider agrees that the Department, Secretary of Health and Human Services or designees have the right to audit and confirm information submitted by the Provider and shall have access to all original source documents, including medical and financial records.
3. The Provider agrees to research and correct any and all, discrepant claims submitted to the Department.
4. The Provider agrees to assume the responsibility to prepare or submit claims and to be solely responsible for errors, omissions and liabilities, regardless of whether claims are submitted by the Provider or by a billing agent.
5. The Provider agrees to assume all costs of hardware and software needed to facilitate the submission of electronic media claims (EMC).
6. The Provider will furnish to the Department the name of the billing agent, the telephone number, and a contact person in the event a billing agent is used for the submission of EMC.
7. The Provider acknowledges that the Provider or the Department may terminate this Rider with a 30-day written notice to the other party.

Section B

Responsibilities of the Department

1. The Department agrees to furnish the Provider with the specifications for submission of electronic media claims.
2. The Department agrees to maintain a phone line to send and receive data and a separate phone line which the Provider may use to address any issues or problems related to claims submission, claims processing and/or remittance information.
3. The Department agrees to produce data on paid/denied claims. Processed claims will be listed on each remittance statement and sent directly to the Provider for purposes of comparison and verification.
4. The Department acknowledges that the Department or the Provider may terminate this Rider with a 30-day written notice to the other party.

Section C

Ratification

In witness whereof, and as consent to this Rider, the parties herein have executed this Rider and ratified it by their signatures found below:

By _____  By _____
 Provider's Signature Date State Department's Signature Date

Printed Name: _____

Printed Name: _____

Title: _____

Title: _____

Facility Name: _____

Please indicate your software:

Provider Number: _____

Hyperterminal: _____

Phone Number: _____

PROCOMMPlus 4.8 _____

Other: _____

If using a billing service, please provide the following:
PLEASE DO NOT LIST YOUR SOFTWARE VENDOR.

Confirmation Report Method: *If you are billing directly to the state, then you must choose one of these options.*

Name of billing service: Claims Processing Service, Inc
dba Emdeon Dental

Phone Number: 888-255-7293

Contact Person: Christine Vincellette

USER ID: 426210000

Callback (phone number of computer to receive call):
NOT USED

Email (email address of person to receive report): _____

FaxBack (the number to your fax machine)
