



**MINNESOTA MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKMN1				
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Business Services Provider Enrollment Form <ul style="list-style-type: none"> Please complete all requested information 				
SEND REGISTRATION FORMS TO:	Please mail or fax completed forms to: <p align="center">Emdeon Business Services 220 Burnham Street South Windsor, CT 06074</p> <p align="center">Fax # 860-289-0055</p>				
ENROLLMENT CONFIRMATION	Enrollment will be coordinated between Emdeon Business Services and Minnesota Medicaid. Emdeon will notify the provider or their software vendor when approval is received.				
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>MN Medicaid Customer Service</td> <td align="right">800-366-5411</td> </tr> <tr> <td>Emdeon Business Services</td> <td align="right">888-255-7293</td> </tr> </table>	MN Medicaid Customer Service	800-366-5411	Emdeon Business Services	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Minnesota Medicaid – payer ID CKMN1**

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

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____