



emdeon™

business services

220 Burnham Street • South Windsor CT 06074

Vox 888-255-7293 • Fax 860-289-0055

**NEVADA MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKNV1				
ELECTRONIC REGISTRATIONS Agreements Required	<p>Emdeon Business Services Provider Enrollment Form</p> <ul style="list-style-type: none"> Please complete all requested information. <p>SERVICE CENTER AUTHORIZATION FORM FOR PROVIDERS</p> <ul style="list-style-type: none"> Please fill in the Provider Name, Provider phone, Provider ID, Group ID (if applicable), Tax ID or SSN, Original Provider Signature and date. 				
SPECIAL NOTES	Please call FSHC provider enrollment department at 877-638-3472 for your provider number.				
SEND REGISTRATION FORMS TO:	Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment				
ENROLLMENT CONFIRMATION	Enrollment will be coordinated between Emdeon Business Services and FHSC. Once approval is received Emdeon 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>First Health Services Corporation</td> <td align="right">877-638-3472</td> </tr> <tr> <td>Emdeon Business Services</td> <td align="right">888-255-7293</td> </tr> </table>	First Health Services Corporation	877-638-3472	Emdeon Business Services	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Nevada Medicaid – payer ID CKNV1**

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: _____
(if applicable)

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

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____

Service Center Authorization

Purpose: To authorize or terminate electronic transactions through a Service Center. A Service Center may be a clearinghouse or a provider business (direct submitter). Electronic transactions are processed only if authorized by the provider by use of this form. For Pharmacy transactions, contact the Technical Call Center at (800) 884-3238.



VOID

Form to First Health Services, EDI Coordinator, PO Box 30042, Reno, NV 89520-3042.

SERVICE CENTER SOURCE: Check one. Enter the business or clearinghouse name as appropriate.									
<input type="checkbox"/> I will submit claims through a clearinghouse. Clearinghouse Name: CPS / WebMD Dental	FIRST HEALTH SERVICES USE ONLY SC Code: 5147								
<div style="border: 2px solid red; border-radius: 15px; padding: 5px; display: inline-block; margin-bottom: 5px;">VOID</div> I will submit claims directly from my business to First Health Services (direct submitter). Business Name: _____									
AUTHORIZE A TRANSACTION: Check the box next to each transaction you wish to authorize.									
<p><i>I hereby authorize the Service Center named above to submit transactions on behalf of the provider until the provider notifies First Health Services otherwise by use of this form.</i></p> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Eligibility Request/Response (270/271)</td> <td><input type="checkbox"/> Professional claim (CMS-1500 claim: 837P)</td> </tr> <tr> <td><input type="checkbox"/> Prior Authorization Request/Response (278/278)</td> <td><input type="checkbox"/> Institutional claim (UB-92 claim: 837I)</td> </tr> <tr> <td><input type="checkbox"/> Claims Status Request/Response (276/277)</td> <td><input type="checkbox"/> Dental claim (Dental Claim: 837D)</td> </tr> <tr> <td><input type="checkbox"/> Electronic Remittance Advice (835)*</td> <td></td> </tr> </table> <p>* Paper remittance advices will cease 30 days after electronic remittance advices begin. Although multiple Service Centers may submit claims for one provider, only one Service Center can receive the electronic remittance advice.</p>		<input type="checkbox"/> Eligibility Request/Response (270/271)	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P)	<input type="checkbox"/> Prior Authorization Request/Response (278/278)	<input type="checkbox"/> Institutional claim (UB-92 claim: 837I)	<input type="checkbox"/> Claims Status Request/Response (276/277)	<input type="checkbox"/> Dental claim (Dental Claim: 837D)	<input type="checkbox"/> Electronic Remittance Advice (835)*	
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<input type="checkbox"/> Electronic Remittance Advice (835)*									
TERMINATE A TRANSACTION: Check the box next to each transaction you wish to terminate.									
<p><i>I no longer authorize the Service Center named above to submit transactions on behalf of the provider unless the provider notifies First Health Services otherwise by use of this form. (Enter the effective date below.)</i></p> <div style="border: 2px solid red; border-radius: 15px; padding: 10px; display: inline-block; margin-bottom: 5px; font-size: 2em; font-weight: bold; color: red;">VOID</div> <table style="width: 100%;"> <tr> <td><input type="checkbox"/> Eligibility Request/Response (270/271)</td> <td><input type="checkbox"/> Professional claim (CMS-1500 claim: 837P)</td> </tr> <tr> <td><input type="checkbox"/> Prior Authorization Request/Response (278/278)</td> <td><input type="checkbox"/> Institutional claim (UB-92 claim: 837I)</td> </tr> <tr> <td><input type="checkbox"/> Claims Status Request/Response (276/277)</td> <td><input type="checkbox"/> Dental claim (Dental Claim: 837D)</td> </tr> <tr> <td><input type="checkbox"/> Electronic Remittance Advice (835)</td> <td></td> </tr> </table> <p>Effective date for termination of this transaction(s): _____</p>		<input type="checkbox"/> Eligibility Request/Response (270/271)	<input type="checkbox"/> Professional claim (CMS-1500 claim: 837P)	<input type="checkbox"/> Prior Authorization Request/Response (278/278)	<input type="checkbox"/> Institutional claim (UB-92 claim: 837I)	<input type="checkbox"/> Claims Status Request/Response (276/277)	<input type="checkbox"/> Dental claim (Dental Claim: 837D)	<input type="checkbox"/> Electronic Remittance Advice (835)	
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I understand that I am responsible for the information presented on claims that are submitted through the Service Center designated above and that all information presented on this authorization form is true, accurate, and complete. I further understand that payment and satisfaction of Nevada Medicaid and Nevada Check Up claims will be from federal and state funds and that false claims, statements, documents or concealment of material facts may be prosecuted under applicable federal and state laws.

Provider Name: _____ Phone: _____

Provider Medicaid Number (one per form): _____

Group Medicaid Number (one per form, if applicable): _____

Federal Tax ID Number (or SSN): _____

Will you be submitting claims that have more than one payer (COB/TPL claims)? Yes No

Provider Signature: _____ Date: _____

