



**OHIO MEDICAID
DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

PAYER ID NUMBER	CKOH1
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Business Services Enrollment Form Please complete all requested information. Group practices <u>MUST</u> list all rendering provider names and rendering NPI numbers.
SEND REGISTRATION FORMS TO:	<p align="center">Please mail completed forms to:</p> <p align="center">Emdeon Business Services Attn: Provider Enrollment 220 Burnham Street South Windsor, CT. 06074</p> <p align="center">Or fax to: 860-289-0055</p>
SPECIAL NOTES	<p>Providers are required to register their NPI information prior to submitting claims electronically. Failure to do so will result in the provider's claims rejecting. To register the office's NPI information, the office must fax the NPPES NPI confirmation letter with the OHMED provider number written on the top. Requests need to be faxed to:</p> <p align="center">PROVIDER ENROLLMENT (614) 995-5904</p> <p>Effective July 1, 2007 Paper Remittance Advices will no longer be mailed to providers. Instead Medicaid providers will access their remittance advices from the internet. ODJFS has established a secure internet website for Medicaid provider to log onto, view, download, save and print their remittance advices. https://medicaidremit.ohio.gov/</p>



emdeon™

business services

220 Burnham Street • South Windsor CT 06074

Vox 888-255-7293 • Fax 860-289-0055

ENROLLMENT CONFIRMATION	Enrollment will be coordinated between Emdeon Business Services and ODJFS. Once approval is received Emdeon Business Services will notify the provider or their software vendor.
CONTACT PHONE NUMBERS	Emdeon Business Services 888-255-7293 MMIS-EDI Support: 614-387-1212



Provider Enrollment Form

Print/Type the following:

Insurance Carrier: **Ohio Medicaid – payer ID CKOH1**

Provider/Organization Name: _____

Tax Identification or Social Security Number: _____
(Number that will be used to submit electronic claims)

Software Vendor: _____

Group NPI: _____
(if applicable)

Name	Rendering NPI
_____	_____
_____	_____
_____	_____
_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Date: _____