



220 Burnham Street • South Windsor, CT 06074  
 Vox 888-255-7293 • Fax 860-289-0055

**WASHINGTON, D.C. MEDICAID  
 DENTAL ELECTRONIC CLAIMS ENROLLMENT REGISTRATION**

|  |   |
|--|---|
| <b>PAYER ID NUMBER</b>                                     | <b>CKDC1</b>  |
| <b>ELECTRONIC REGISTRATIONS</b><br><br>Agreements Required | <b>Emdeon Business Services Provider Enrollment Form</b> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul> <b>Washington, D.C. ACS EDI Provider Enrollment Form</b> <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul> |
| <b>SEND REGISTRATION FORMS TO</b>                          | Emdeon Business Services<br>220 Burnham Street<br>South Windsor, CT 06074<br>Attn: Provider Enrollment<br>Or<br>Fax to: 860-289-0055  |
| <b>ENROLLMENT CONFIRMATION</b>                             | Enrollment will be coordinated between Washington, D.C. Medicaid and Emdeon Business Services. Once approval is received Emdeon will notify the provider or their software vendor.  |
| <b>CHANGING ELECTRONIC BILLING AGENTS</b>                  | 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.  |
| <b>CONTACT PHONE NUMBERS</b>                               | ACS EDI Helpdesk <span style="float: right;">866-775-8563</span><br>Emdeon Business Services <span style="float: right;">888-255-7293</span>  |



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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Washington, D.C. - payer ID CKDC1**

Provider/Organization Name: \_\_\_\_\_

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

Software Vendor: \_\_\_\_\_

Group Number: \_\_\_\_\_  
*(if applicable)*

| Name  | Rendering | Number |
|-------|-----------|--------|
| _____ | _____     | _____  |
| _____ | _____     | _____  |
| _____ | _____     | _____  |
| _____ | _____     | _____  |

Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

Office Contact Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Date: \_\_\_\_\_

Washington, D.C. ACS EDI Provider Enrollment Form



Please return to:  
ACS  
Attn: Technical Support/Enrollment  
PO Box 34734  
Washington DC 20043-4761  
Or fax to: 202-906-8399



Provider ACS EDI Gateway Authorization form for Billing Agents and Clearinghouses.

Section A. Provider Information.

Please indicate your classification (required):  Individual Provider  Group Provider/Practice

Business Person

Provider Name (Last, First, MI and Suffix)

Provider Number (Required for Individuals)

Group Provider Number (Required for Groups)

Business Address

City, State, and Zip

Telephone Number

Fax Number

Contact Name

E-mail Address

Section B. Authorization Signature (required).

Provider, \_\_\_\_\_ hereby appoints  
*Provider name /Provider Representative name (please print)*

ENVOY LLC, EMDEON BUS SER CO,  
*Billing Agent/Clearinghouse name (please print)*

90185  
*Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID*

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc.  
Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- 277-Claims Status Response
- 271-Eligibility Response
- 824-Error Report
- 835-Healthcare Claims Payment Advice
- 278-Prior Authorization Response

\_\_\_\_\_  
*Provider/Provider Representative name (Please print)*



\_\_\_\_\_  
*Provider/Provider Representative Signature*

\_\_\_\_\_  
*Date*