



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

Participation in Dental Electronic Remittance Advice (ERA) is limited to those provider's whose practice management software vendor is participating in ERA with Emdeon or to those provider's who have a Dental Provider Services (DPS) account. Please contact your software vendor to verify participation or register for a DPS account at www.emdeondental.com

AETNA
 DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	60054
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Dental Provider Enrollment Form <ul style="list-style-type: none"> • Please complete all requested information. Electronic Remittance Advice (ERA) & Electronic Fund Transfer (EFT) Request Form <ul style="list-style-type: none"> • Please complete all requested information
SPECIAL NOTES	Electronic Fund Transfer (EFT) is not required to participate with ERA. Paper Remittance Advice will continue to be mailed for approximately 30 days after ERA is approved.
SEND REGISTRATION FORMS TO	Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment Or Fax to: 860-289-0055
ENROLLMENT CONFIRMATION	ERA enrollments take approximately 10-15 business days for completion. Once complete, Emdeon Dental will notify the provider or their software vendor to expect to begin receiving ERAs from Aetna.
CHANGING ELECTRONIC BILLING AGENTS	If the Provider currently receives ERAs through another Billing Agent other than Emdeon Business Services each Provider must re-enroll following the procedures listed above.



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<p>DISCONTINUING ERA</p>	<p>Discontinuing ERA is a 2 step process.</p> <ol style="list-style-type: none"> 1. Deactivation <ol style="list-style-type: none"> a. Providers receiving ERAs via their Practice Management Software need to request deactivation from their software Vendors. Please call your PMS directly. b. Providers receiving their ERAs via an Emdeon DPS account need only ignore the ERA option when logging into the DPS. 2. Payer Un-enrollment <ol style="list-style-type: none"> a. Each payer has their own unique process to discontinue ERAs and return to paper Remittance Advice. Please follow the below steps for this payer. <p>Provider would need to mark Cancel and complete section A of the Electronic Remittance Advice & Electronic Fund Transfer Request Form and fax to 859-455-8650.</p>				
<p>CONTACT PHONE NUMBERS</p>	<table> <tr> <td>Aetna</td> <td>800-451-7715</td> </tr> <tr> <td>Emdeon Business Services Provider Enrollment</td> <td>888-255-7293</td> </tr> </table>	Aetna	800-451-7715	Emdeon Business Services Provider Enrollment	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: Aetna - ERA payer ID 60054

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: _____

Email Address: _____

Date: _____



Electronic Remittance Advice (ERA) & Electronic Fund Transfer (EFT) Request Form

EFT Registration – complete Section A, Part I, and sign below

- EFT - Dental claim product payments and Dental Maintenance Organization (DMO®) Monthly Compensation
- Change to existing registration

ERA Registration – complete Section A and Part II and sign below

- ERA - Dental claim EOB ERA - Dental Maintenance Organization (DMO®) Monthly Compensation
- Change to existing registration

Cancel – complete Section A

- Cancel Electronic Funds Transfer Cancel Electronic Remittance Advice

SECTION A - Please complete the following information for all requests:

Practice Information:

Name: _____ Tax Identification Number (TIN): _____

Contact Name: _____ E-Mail Address: _____

National Provider Identification (NPI): _____

Phone Number () _____ Fax Number () _____

Addresses:

Primary Service: _____ Primary Billing: _____

PART I - Please complete the following bank account information for EFT:

To take advantage of direct deposit (EFT), your bank must be a participating member of the Automated Clearinghouse Association (ACH). Please note if you require payments to be deposited into multiple bank accounts, bank account information must be completed for each account. New EFT registration or changes to existing EFT banking information will trigger a new EFT pre-note period. The EFT pre-note period will run for 10 days from the effective date. Production will start on day 11. You are responsible for notifying Aetna if your banking information should change.

Bank Name _____ Contact Phone Number _____

Bank ID (first 8 digits of the routing number) _ _ _ _ _

Bank SCD (self-checking digit / the last digit of the routing number) _

Account Number _____ Account Type Savings or Checking

Please include a copy of your cancelled check or Savings Account Deposit Ticket

Authorization Agreement for Direct Deposit of Benefits Payments. Please read and sign your name below.

I hereby authorize Aetna, on behalf of itself and its affiliates, including but not limited to Aetna Life Insurance Company, Aetna Dental Inc, and Aetna Health Inc. (hereinafter "Company") to initiate credit entries to the account(s) at the bank(s) listed above for all benefits payments. This agreement will remain in effect until I notify Company of the desire to cancel or change this service or until Company notifies me that this service has been terminated. I understand that I must allow reasonable time for my instructions to be executed. If Company credits more money than the correct benefit amount to the account due to duplicate electronic funds transfers (where "duplicate" is defined as multiple electronic funds transfers received for the same services rendered, the same membership, and the same dates of service) or erroneous electronic funds transfers (where erroneous is defined as complete electronic funds transfers received in error), I authorize Company to withdraw the overpayment. I authorize and request the bank listed above to accept any credit entries by Aetna to such account and to credit the same to such account. (For Internal Purpose Only - PRIN)



PART II – Please complete the following ERA vendor information

Before submitting this request, please review your vendor options on www.aetnadental.com and complete all applicable vendor registrations. Paper Explanation of Benefits (EOB) will be discontinued after 30 days.

ERA Vendor requested: Emdeon Business Services

Electronic Remittance Advice (ERA) – Pended Claims

When state requirements require information that cannot be accommodated in our HIPAA compliant ERA transaction such as information regarding pended claims, health care professionals can obtain this information in other ways:

- For pended claims received **electronically**, the request for information is returned in a Claim Status Response (277). However, Aetna is aware that some providers have agreements with their vendor/clearinghouse to receive some, all or none of their unsolicited claim status responses. Therefore, please work with your vendor/clearinghouse to ensure that you receive all level 2 claim status responses in order to receive this information. If you prefer, or are unable to receive these responses, you may utilize the real- time claims status inquiry transaction to obtain this information as well.
- For pended claims received on **paper**, a request for more information may be sent by letter or phone call. However if you have not received any such request within 30 days of a claim submission on paper, please utilize the claim status inquiry transaction to view this information.

For more information on using claim status inquiry transaction, refer to www.aetnadental.com.

Thank you for your cooperation in this effort.

By signing below, I hereby agree that I have read and agree to the terms and conditions stated above including Authorization for Direct Deposit of Benefits Payments, Legislative Updates and Pended Claims.

NOTE: Two signatures required for completion of request.

Form completed by:

Please Print Name _____

Date _____

Signature _____



Date _____

Authorized by:

Please Print Name _____

Date _____

Authorized Signature _____



Date _____