



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](http://www.emdeondental.com)**

ALASKA MEDICAID  
 DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKAK1
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Dental Provider Enrollment Form <ul style="list-style-type: none"> <li>• Please complete all requested information.</li> </ul> Provider Electronic Remittance (835) Authorization <ul style="list-style-type: none"> <li>• Please complete all requested information</li> </ul>
SEND REGISTRATION FORMS TO	Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment
ENROLLMENT CONFIRMATION	ERA enrollments take approximately 10-15 business days for completion. Once complete, Emdeon will notify the provider or their software vendor.
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"> <li>1. Deactivation           <ol style="list-style-type: none"> <li>a. Providers receiving ERAs via their Practice Management Software need to request deactivation from their software Vendors. Please call your PMS directly.</li> <li>b. Providers receiving their ERAs via an Emdeon DPS account need only ignore the ERA option when logging into the DPS.</li> </ol> </li> <li>2. Payer Un-enrollment           <ol style="list-style-type: none"> <li>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.</li> </ol> </li> </ol> <p>No un-enrollment is necessary as the provider will always continue to receive paper remittance advice statements.</p>				
<p>CONTACT PHONE NUMBERS</p>	<table> <tr> <td>First Health Services (AK Medicaid)</td> <td>907-644-6836</td> </tr> <tr> <td>Emdeon Business Services Provider Enrollment</td> <td>888-255-7293</td> </tr> </table>	First Health Services (AK Medicaid)	907-644-6836	Emdeon Business Services Provider Enrollment	888-255-7293
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**PROVIDER ENROLLMENT FORM**

Print/Type the following:

Insurance Carrier: **Alaska Medicaid - ERA payer ID CKAK1**

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

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

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

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

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

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

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

## Provider Electronic Remittance (835) Authorization

Alaska Medical Assistance is capable of sending an 835 transaction to a single entity/organization only. The purpose of this form is to allow providers to designate who should receive their 835. Please complete the following form for this designation and indicate all State Provider Identification Number(s) and corresponding National Provider Identifier (NPI) number(s) that are applicable.

### Send My 835 To:

- Self (practice management software able to receive)
- Billing Agent
- Clearinghouse
- Other

**Organization Name:** Claims Processing Services dba Emdeon Business Service

**Contact Name:** Dawn L Vaughan

**Phone Number:** 888-255-7293

**Provider Name:** \_\_\_\_\_

**State Provider Identification Number** \_\_\_\_\_ **Corresponding NPI#** \_\_\_\_\_

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**State Provider Identification Number** \_\_\_\_\_ **Corresponding NPI#** \_\_\_\_\_

**State Provider Identification Number** \_\_\_\_\_ **Corresponding NPI#** \_\_\_\_\_

**Telephone #:** \_\_\_\_\_

Attach additional pages if necessary

I authorize the above named entity to receive and process my electronic remittances (835) from Alaska Medical Assistance Programs. I may have multiple entities submitting claims for me and understand that only one entity can be designated by me to accept and process my electronic remittance. I also understand that the entity I have authorized above must have prior approval from First Health Services to receive electronic remittances.

\_\_\_\_\_  
**Print Authorized Representative Name**

\_\_\_\_\_  
**Title Authorized Representative**



\_\_\_\_\_  
**Signature of Provider\* or Authorized Representative\*\***

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

\* *Individuals and sole proprietors must sign their own enrollment agreement form.*

\*\* *An authorized representative is an appointed official to whom the provider has granted the legal authority to enroll the provider in the Medicaid program, to make changes and/or updates to the provider's status in the Medicaid program (e.g., new practice locations, changes of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of the Medicaid program. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider's organization, or must hold a position of similar status and authority within the provider's organization.*

*If you fax this document, please be sure to mail the original.*

**Mail Original or Fax to:** First Health Services Corporation  
HIPAA Provider Support Team  
P.O. Box 240808  
Anchorage, AK 99524-0808

Fax Number: (907) 644-8126