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

ALABAMA MEDICAID
DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKAL1
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Dental Provider Enrollment Form • Please complete all requested information. Electronic Explanation of Payment (EOP) Agreement • Please complete all requested information.
SPECIAL NOTES	Paper Explanation of Payment information will cease to be mailed to the mailing address maintained at EDS upon approval of this application.
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 2-4 weeks for completion. Once complete, Emdeon Dental will notify the provider or their software vendor to expect to begin receiving ERAs from Maryland Medicaid.
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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DISCONTINUING ERA	Discontinuing ERA is a 2 step process. 1. Deactivation 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 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. Providers who wish to discontinue receiving ERAs need to contact Alabama Medicaid Provider Enrollment at 800-456-1242 or 334-215-0111 with their request.
CONTACT PHONE NUMBERS	Alabama Medicaid In state providers 800-456-1242 Alabama Medicaid Out of state providers 334-215-0111 Emdeon Business Services Provider Enrollment 888-255-7293

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PROVIDER ENROLLMENT FORM

Print/Type the following:
Insurance Carrier: **Alabama Medicaid - ERA payer ID CKAL1**

Provider/Organization Name: ____

Tax Identification or Social Security Number: ____________________________
(Number used to submit electronic claims)

Software Vendor: ____

Group Number: ___________________________
(If applicable)

Group NPI: ______________________________
(if applicable)

Name	Rendering Number	NPI

Address: ____

City, State, Zip Code: ____

Office Contact Name: ____

Telephone Number: __________________ Fax Number: ________________

Email Address: ____

Date: ______________________________

ELECTRONIC EXPLANATION OF PAYMENT (EOP) AGREEMENT

GROUP/BILLING PROVIDER NUMBER: ______________________________

GROUP/BILLING NAME: ______________________________

ADDRESS: ______________________________

CITY: ____________________ **STATE:** __________ **ZIP:** __________

CONTACT: ____________________ **PHONE NUMBER:** __________

TRADING PARTNER ID: 300001362

VENDOR NAME: Claims Processing Service, Inc. dba Emdeon Business Services - Dental

ADDRESS: 220 Burnham Street

CITY: South Windsor **STATE:** CT **ZIP:** 06074

VENDOR PHONE NUMBER: 860-289-6090

VENDOR CONTACT: Dawn L Vaughan

I (we) request to receive Electronic Explanation of Payment (EOP) information and authorize the information to be deposited in our electronic mailbox. I (we) accept financial responsibility for costs associated with receipt of Electronic EOP information.

I (we) understand that paper-formatted EOP information will continue to be sent to my (our) mailing address as maintained at EDS until I (we) submit an Electronic EOP Certification Request Form.

I (we) will continue to maintain the confidentiality of records and other information relating to recipients in accordance with applicable state and federal laws, rules, and regulations.

Authorized Signature: ______________________________ **Date:** __________

Title: ____________________ **Email Address:** ____________________

Mail form to: EDS • Attn: ECS Department • P.O. Box 244035 • Montgomery, AL 36124
FAX form to: 334-215-4272 Attn: ECS Department

FOR EDS USE ONLY

BILLING MODE: __________ **EOP MODE:** __________ **PROTOCOL:** __________

CONTACT DATE: __________ **SOFTWARE MAILED:** __________

TEST DATE: __________ **AGREEMENT DATE:** __________ **APPROVAL DATE:** __________

BEGIN DATE: __________ **END DATE:** __________

NOTES: ______________________________