



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

IDAHO MEDICAID
 DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKID1
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Dental Provider Enrollment Form <ul style="list-style-type: none"> • Please complete all requested information. Idaho Medicaid Program Electronic Remittance Advice (ERA) Authorization <ul style="list-style-type: none"> • Please complete all requested information.
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 5-7 business days for completion. Once complete, Emdeon Dental will notify the provider or their software vendor to expect to begin receiving ERAs from Idaho 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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<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>Providers who wish to discontinue receiving ERAs need to contact Idaho Medicaid Provider Enrollment at 800-685-3757.</p>				
<p>CONTACT PHONE NUMBERS</p>	<table> <tr> <td>Idaho Medicaid</td> <td>800-685-3757</td> </tr> <tr> <td>Emdeon Business Services Provider Enrollment</td> <td>888-255-7293</td> </tr> </table>	Idaho Medicaid	800-685-3757	Emdeon Business Services Provider Enrollment	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Idaho Medicaid - ERA payer ID CKID1**

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: _____
(if applicable)

Name	Number	Rendering	NPI
_____	_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Date: _____

Idaho Medicaid Program Electronic Remittance Advice (ERA) Authorization

The Idaho Department of Health and Welfare (DHW) has adopted the American National Standards Institute (ASC X12N 835 4010A1), Accredited Standards Committee (ASC) X12N Health Care Claim Payment/Advice (ANSI 835) as the standard format for the electronic data interchange (EDI) of Medicaid claim payment data for Medicaid services. ERAs will be made available to the authorizing provider or his agent in the ANSI 835 format on the Idaho Bulletin Board System (BBS). The implementation guide for ANSI transaction (835) is available at www.wpc-edi.com. A provider may elect to receive both a paper and an electronic remittance advice.

I, (Print Name) _____ understand the electronic remittance advice contain similar financial information as paper RAs.

Signature: _____  Date: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ BBS ID (Required): 445883154

Provider Number(s): _____

Electronic RA only _____ both a paper and electronic RA _____

I, (Print Name) _____ hereby certify that the billing service or VAN listed below is authorized to receive an electronic remittance advice on my behalf. I agree that if the billing arrangement with the identity listed below is terminated, I will immediately report that termination in writing to EDS.

Signature: _____  Date: _____

Name: Claims Processing Service, Inc.

Address: 220 Burnham Street

City: South Windsor State: CT Zip: 06074

Phone: 860-289-6090 Contact: Provider Enrollment

Please return to:

EDS
Attention: EDI TEAM
P. O. Box 23
Boise, ID 83707
1-800-685-3757
FAX 208-395-2198