



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

INDIANA MEDICAID AND INDIANA CHILDREN'S SPECIAL HEALTHCARE PROGRAM
 DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

<p>PAYER ID NUMBER</p>	<p>CKIN1 CX070</p>
<p>ELECTRONIC REGISTRATIONS</p> <p>Agreements Required</p>	<p>Emdeon Dental Provider Enrollment Form</p> <ul style="list-style-type: none"> • Please complete all requested information. <p>EDI Outbound Transactions Request</p> <ul style="list-style-type: none"> • Please complete all requested information. • All providers listed on the form must sign the form. • Only the billing provider information needs to be listed if practice is a group practice. <p>**A letter of authorization is required if someone other than you will retrieve the ANSI 276/278 or 835 transaction response. Please attach an authorization letter on your letterhead with the entire enrollment packet granting Emdeon permission to download your reports. **</p>
<p>SEND REGISTRATION FORMS TO</p>	<p>MAIL ORIGINAL FORMS TO:</p> <p style="text-align: center;">Emdeon Business Services 220 Burnham Street South Windsor, CT 06074 Attn: Provider Enrollment</p>
<p>ENROLLMENT CONFIRMATION</p>	<p>ERA enrollments take approximately 5-7 business days of completion. Once complete, Emdeon Dental will notify the provider or their software vendor to expect to begin receiving ERAs from Indiana Medicaid and Indiana Children's Special Healthcare Programs.</p>
<p>CHANGING ELECTRONIC BILLING AGENTS</p>	<p>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.</p>



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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>If a provider wishes to discontinue receiving ERAs from Emdeon the provider needs to re-enroll for ERA retrieval through the Indiana Medicaid web portal selecting another entity to retrieve their ERAs from Indiana Medicaid.</p>				
<p>CONTACT PHONE NUMBERS</p>	<table style="width: 100%; border: none;"> <tr> <td style="width: 60%;">IHCP Support Help Desk</td> <td style="text-align: right;">317-488-5160 or 877-877-5182</td> </tr> <tr> <td>Emdeon Business Services Provider Enrollment</td> <td style="text-align: right;">888-255-7293</td> </tr> </table>	IHCP Support Help Desk	317-488-5160 or 877-877-5182	Emdeon Business Services Provider Enrollment	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Indiana Medicaid and Indiana Children's Special Healthcare Program - ERA payer ID CKIN1 AND CX070**

Provider/Organization Name: _____

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

Software Vendor: _____

Group Number: _____ / _____
(If applicable) Indiana Medicaid Indiana Children's Special Healthcare Program

Group NPI Number: _____
(if applicable)

Name	Number	Rendering	NPI
_____	Indiana Medicaid	Indiana Children's Special Healthcare Program	_____
_____	Indiana Medicaid	Indiana Children's Special Healthcare Program	_____
_____	Indiana Medicaid	Indiana Children's Special Healthcare Program	_____
_____	Indiana Medicaid	Indiana Children's Special Healthcare Program	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Date: _____



EDI OUTBOUND TRANSACTIONS REQUEST

Date	Trading Partner ID Used to Retrieve File(s) P175	Check one <input type="checkbox"/> Clearinghouse <input type="checkbox"/> Trading partner <input type="checkbox"/> Billing company <input type="checkbox"/> Provider
Company/Provider		
Street		Suite
City		State ZIP Code+4 -
Telephone No. ()	E-mail Address	

Enroll these Indiana Health Coverage Programs (IHCP) providers to receive the outbound transaction files, as indicated.

Provider Name	LPI/NPI	Taxonomy	ZIP Code+4	Transaction Type	Signed Release
	LPI NPI		-	<input type="checkbox"/> 835 <input type="checkbox"/> 270/271 <input type="checkbox"/> 278	<input type="checkbox"/> Yes <input type="checkbox"/> No
	LPI NPI		-	<input type="checkbox"/> 835 <input type="checkbox"/> 270/271 <input type="checkbox"/> 278	<input type="checkbox"/> Yes <input type="checkbox"/> No
	LPI NPI		-	<input type="checkbox"/> 835 <input type="checkbox"/> 270/271 <input type="checkbox"/> 278	<input type="checkbox"/> Yes <input type="checkbox"/> No
	LPI NPI		-	<input type="checkbox"/> 835 <input type="checkbox"/> 270/271 <input type="checkbox"/> 278	<input type="checkbox"/> Yes <input type="checkbox"/> No
	LPI NPI		-	<input type="checkbox"/> 835 <input type="checkbox"/> 270/271 <input type="checkbox"/> 278	<input type="checkbox"/> Yes <input type="checkbox"/> No
	LPI NPI		-	<input type="checkbox"/> 835 <input type="checkbox"/> 270/271 <input type="checkbox"/> 278	<input type="checkbox"/> Yes <input type="checkbox"/> No
	LPI NPI		-	<input type="checkbox"/> 835 <input type="checkbox"/> 270/271 <input type="checkbox"/> 278	<input type="checkbox"/> Yes <input type="checkbox"/> No

For EDS to permit this company to retrieve the outbound transaction files for the listed providers, release letters from each provider must be on file. The release letters must be signed and dated and contain the provider name, address, and provider number. The release letters must accompany a completed *EDI Outbound Transactions Request*. ~~Fax or mail the completed forms to:~~



If the forms are faxed to EDS, the originals must be mailed to EDS at the address indicated.

If this request is submitted by a provider for that same provider, this request, signed and dated, serves as the release letter.

Requestor Signature	Date