



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

WASHINGTON, D.C. MEDICAID
 DENTAL ELECTRONIC REMITTANCE ADVICE (ERA) ENROLLMENT REGISTRATION

PAYER ID NUMBER	CKDC1
ELECTRONIC REGISTRATIONS Agreements Required	Emdeon Dental Provider Enrollment Form <ul style="list-style-type: none"> • Please complete all requested information. Washington, D.C. ACS EDI Provider Enrollment Form <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 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"> 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 Washington, D.C. Medicaid he must mail a letter of request on his letterhead which contains the provider's full name, tax ID and Provider ID with the reason for discontinuance to:</p> <p style="text-align: center;">ACS Provider Enrollment Unit PO Box 4761 Washington, DC 20043-4761</p>				
<p>CONTACT PHONE NUMBERS</p>	<table style="width: 100%; border: none;"> <tr> <td style="border: none;">ACS EDI Helpdesk</td> <td style="border: none; text-align: right;">866-75-8563</td> </tr> <tr> <td style="border: none;">Emdeon Business Services Provider Enrollment</td> <td style="border: none; text-align: right;">888-255-7293</td> </tr> </table>	ACS EDI Helpdesk	866-75-8563	Emdeon Business Services Provider Enrollment	888-255-7293
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PROVIDER ENROLLMENT FORM

Print/Type the following:

Insurance Carrier: **Washington, D.C. Medicaid - ERA payer ID TBD**

Provider/Organization Name: _____

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

Software Vendor: _____

Group Number: _____
(If applicable)

Name	Rendering	Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Address: _____

City, State, Zip Code: _____

Office Contact Name: _____

Telephone Number: _____ Fax Number: _____

Email Address: _____

Date: _____

Washington, D.C. ACS EDI Provider Enrollment Form



Please return to:
ACS
Attn: Technical Support/Enrollment
PO Box 34734
Washington DC 20043-4761
Or fax to: 202-906-8399



Provider ACS EDI Gateway Authorization form for Billing Agents and Clearinghouses.

Section A. Provider Information.

Please indicate your classification (required): Individual Provider Group Provider/Practice

Business Person

Provider Name (Last, First, MI and Suffix)

Provider Number (Required for Individuals)

Group Provider Number (Required for Groups)

Business Address

City, State, and Zip

Telephone Number

Fax Number

Contact Name

E-mail Address

Section B. Authorization Signature (required).

Provider, _____ hereby appoints
Provider name /Provider Representative name (please print)

ENVOY LLC, EMDEON BUS SER CO

90185

Billing Agent/Clearinghouse name (please print)

Billing Agent/Clearinghouse ACS Trading Partner/Submitter ID

to act as the authorized agent for the purpose of submitting health care transactions electronically to ACS EDI Gateway, Inc. Provider also authorizes the Billing Agent/Clearinghouse's access to the following X12N transaction responses if selected below:

- 277-Claims Status Response
- 271-Eligibility Response
- 824-Error Report
- 835-Healthcare Claims Payment Advice
- 278-Prior Authorization Response

Provider/Provider Representative name (Please print)



Provider/Provider Representative Signature

Date