

PAYER ID:

SUBMITTER ID:



Emdeon ERA Provider Information Form

**This form is to ensure accuracy in updating the appropriate account*

1 Provider Organization					
Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
2 Vendor <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					
3 Payer					
Payer ID					
Group ID	Individual Provider ID		NPI ID		
4 Confirmations					
Send Emdeon Claim Confirmations To:					
Special Instructions:					
<ul style="list-style-type: none"> All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted. SUBMIT COMPLETED FORM TO: Fax: (615) 231-4843 Email: batchenrollment@Emdeon.com 					
EMDEON REVISION FORM DATE:					



Group/Provider Access Information for 835 Transaction Set

Date: _____ Please Provide Current UserID(e.g SFT0001) _____

Section I Please complete a separate form for each Group and Provider number receiving a reimbursement voucher. (Information should be obtained from your most recent reimbursement voucher, see sample below)

Billing National Provider ID# (NPI): _____ (Required)

(1) CDPHP's Group or Provider number: _____

(2) Tax ID of Group/Provider: _____

Voucher/Remit Name and Address (Please print or type)

(3) Group/Provider Name: _____

(4)Address 1: _____

(5)Address 2: _____

(6)City: _____ State: _____ Zip Code: _____

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC. (CDPHP) PATROON CREEK CORPORATE CENTER 500 PATROON CREEK BLVD. ALBANY, NEW YORK 12206-1057	PAYMENT VOUCHER
<p>3 Group/Provider Name</p> <p>4 Group/Provider Address 1</p> <p>5 Group/Provider Address 2</p> <p>6 Group/Provider City, State Zip</p>	DATE: _____ PAGE: TIN: 2 P 99999999 or CHECK # G 9999 1 AMOUNT: _____
	FOR TELEPHONE INQUIRIES CALL: (518) 641.3500

Section II

Contact Information (Provider office contact)

Business Contact Name: _____ Title: _____

Telephone: _____ Ext.: _____ Fax: _____

E-mail Address: _____

Address 1: _____

Address 2: _____

City: _____ State: _____ Zip Code: _____

Section III

Technical Contact Information (Vendor Contact details)

Technical Contact Name: ENROLLMENT HELP DESK Title: _____
Telephone: 800-845-6592 Ext.: _____ Fax: 615-231-4843
E-mail Address: payerregistration@emdeon.com
Address 1: 26 CENTURY BLVD STE 601
Address 2: _____
City: NASHVILLE State: TN Zip Code: 37214

Complete the following only if you will have a 3rd party vendor retrieving your 835 transactions from CDPHP:

I authorize EMDEON to act as my agent to view Capital District Physicians' Health Plan, Inc. (CDPHP), Capital District Physicians' Healthcare Network, Inc. (CDPHN) or CDPHP Universal Benefits, Inc. (UBI) member data, including possible protect health information (PHI) in any format deemed appropriate by CDPHP, CDPHN or UBI, on my behalf. The entity listed above is my authorized business associate. I authorize the entity listed above to receive correspondence related to the submittal and processing of ANSI X12 835 transactions on my behalf.

Signature: _____ Date: _____

Title: _____ Employer: _____

The NPI number should be the group practice's billing NPI, facility billing NPI, or individual practitioner NPI if a sole practitioner.

Please fax or mail to:

CDPHP
Network Services department
500 Patroon Creek Blvd.
Albany, NY 12206
FAX#: 518-641-3209

If you have connectivity questions, please contact the EDI_Team@cdphp.com or 518-641-4EDI(4334).

If you have questions concerning Section I through III, please contact Provider Services:

Capital area @ (518) 641-3500 or 1-800-926-7526, Central region @ 1-877-260-0512, Hudson Valley region @ 1-877-260-0801.