

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:					



ELECTRONIC FUNDS TRANSFER AGREEMENT

Providers who receive payment of claims by BCHP must agree to the following terms and conditions:

1. **EFT Information**. Provider will submit EFT information noted below that includes the name of the entity listed on your W-9 (“Payee”), name of the bank, bank routing number, bank account number to which funds will be transferred. Provider will notify the BCHP in writing at least ten (10) days in advance of any changes in Payee, Payee’s name or address, or bank account name or number.
2. **Non-Provider Payee**. If the Payee indicated on the EFT information below is different from the contracted Provider and/or Group Practice, Provider must submit to BCHP a signed and notarized Power of Attorney for Payee. Designation of a Payee other than Provider shall not relieve Provider of any liability for acceptance of medical assistance payments under the Medicaid program. Provider acknowledges and agrees that Payee is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable. Any payments to the Payee shall be related to the cost of processing, and shall not be based on the percentage of amounts paid or upon collection of the payments.
3. **Payment of Funds**. Provider authorizes BCHP to credit and debit the proper account to Payee’s bank pursuant to an EFT and is sufficient to show acceptance of payments. Provider certifies by such acceptance that Provider submitted the claims for the services shown on the explanation of payment issued by BCHP, and that the services were rendered by or under the supervision of Provider. BCHP may elect for good cause to substitute payment by paper check for EFT until the cause requiring the substitution has been satisfied as determined by the BCHP. Payment by check will be made to the address for payments on record with BCHP.



4. **Termination.** Breach of these terms may cause termination of EFT by BCHP. Provider's termination of network participation for any reason will terminate EFT automatically.

Signature of Provider or Administrator

Date

ELECTRONIC FUNDS TRANSFER AGREEMENT

Payee Name: _____

Payee Phone Number: _____

IRS#: _____

Bank Name: _____

Bank Address: _____

Bank City, State & Zip: _____

Bank Routing #: _____ Bank Account #: _____

EFT

- Yes, please send electronic funds transfer to the account listed above
 No, please send a paper check

835

- Yes, please send electronic explanation of payment
 Clearinghouse Name: EMDEON
 Clearinghouse ID#: 95831
 Sender/Receiver ID: _____ (direct claim submitters only)
 Technical Contact Name: ENROLLMENT HELP DESK Phone #: 866-924-4634
- No, please do not send an electronic explanation of payment



Remit

- Yes, please send a paper copy of the explanation of payment
- No, please do not send a paper copy of the explanation of payment

If you answer yes to both “835” and “Remit”, the paper copy will discontinue after 60 days.

Return form to: **Attn: Provider Relations**
 Buckeye Community Health Plan
 175 S. Third Street, Suite 200
 Columbus, OH 43215

Fax Numbers:
Northeast Region (Cleveland) 866-753-7543
East Central Region (Akron) 866-528-9951
Northwest Region (Toledo) 866-671-3660
Southwest Region (Cincinnati)866-205-0586

For Internal Use Only:

PSHP rcvd:	Payee #:	Finance:	PSHP:
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