

PAYER ID:

SUBMITTER ID:



## Emdeon ERA Provider Information Form

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

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

Providers who receive payment of claims by Managed Health Services (MHS) 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 MHS 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 MHS 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 Managed Health Services 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 MHS, and that the services were rendered by or under the supervision of Provider. MHS 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 MHS. Payment by check will be made to the address for payments on record with MHS.
4. **Termination.** Breach of these terms may cause termination of EFT by MHS. Provider’s termination of network participation for any reason will terminate EFT automatically.

\_\_\_\_\_  
Signature of Provider or Administrator

\_\_\_\_\_  
Date



ELECTRONIC FUNDS TRANSFER AGREEMENT

Real Life Solutions for Health Care
Managed Health Services

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: Managed Health Services
1099 N. Meridian Street
Suite 400
Indianapolis, IN 46204

Fax to: 1-866-912-4241

For Internal Use Only:

Table with 4 columns: MHS rcvd, Payee #, Finance, MHS