

PAYER ID:

SUBMITTER ID:



emdeon™

## 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><b>SUBMIT COMPLETED FORM TO:</b>            Fax: (615) 231-4843            Email: <a href="mailto:batchenrollment@Emdeon.com">batchenrollment@Emdeon.com</a></li> </ul>					
<p>Payer can no longer process EFT requests without a voided check (no deposit slips please). Payer requires the ABA number from the voided check. EFT's fail with the deposit slip ABA numbers.</p>					
EMDEON REVISION FORM DATE:					



# ERA Enrollment Form

Please Fax or E-mail Completed Forms to:  
Fax: (818) 234-9966  
EDIENROLL-CA@Wellpoint.com  
**Anthem Blue Cross**  
ATTN: EDI Solutions CAAC07-077B  
PO Box 4173, Woodland Hills, CA 91365-4173  
EDI Technical Support: (800) 227-3983

**Incomplete enrollment packages will be returned unprocessed**

**Please print clearly. A separate form is required for each Tax Identification Number.**

Provider Name: \_\_\_\_\_

Tax ID #: \_\_\_\_\_ NPI #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Physical Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Contact Name: \_\_\_\_\_ Title: \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Please indicate method of retrieval for your Anthem Blue Cross Electronic Remittance Advice (ERA) file:**

- We are a direct claim submitter and will download our own ERA files.  
Our electronic mailbox ID is (ex: ZHCQ0000) \_\_\_\_\_  
Our ERA translation software is \_\_\_\_\_
- Please assign a new mailbox to download our own ERA files.  
Our ERA translation software is \_\_\_\_\_
- We are switching vendors. Please discontinue our current ERA services with vendor: \_\_\_\_\_
- Our vendor will retrieve all ERA files for us. (Please have vendor complete the following fields.)

Vendor Name: EMDEON

Vendor Contact Name: ENROLLMENT HELP DESK

Vendor Contact Phone: 800-845-6592

Vendor Email: PAYERREGISTRATION@EMDEON.COM

*Note: Please make sure vendor is set up to receive ERA files from Blue Cross of California. We can not process this request if they are not set up.*

***A Company Officer must sign this form. This is a legal document***

**PRINT NAME:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

**TITLE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_



# EFT Enrollment Form

Please Fax or E-mail Completed Forms to:  
Fax: (818) 234-9966  
EDIENROLL-CA@Wellpoint.com  
**Anthem Blue Cross**  
ATTN: EDI Solutions CAAC07-077B  
PO Box 4173, Woodland Hills, CA 91365-4173  
EDI Technical Support: (800) 227-3983

**Incomplete enrollment packages will be returned unprocessed**

Anthem Blue Cross Systems is hereby authorized to deposit payments for claims to the account listed below.  
**A voided blank check or bank authorization letter is required for the account receiving the direct deposit.**

**DEPOSIT SLIPS ARE NOT ACCEPTED UNDER ANY CIRCUMSTANCES.**

<b>PROVIDER NAME (REQUIRED)</b>		<b>MEDICARE PROVIDER NUMBER (REQUIRED)</b>	
<b>ADMINISTRATIVE CONTACT: (REQUIRED)</b>		<b>TAX ID NUMBER: (REQUIRED)</b>	
<b>TITLE: (REQUIRED)</b>		<b>PHONE NUMBER: (REQUIRED)</b>	

## BANK INFORMATION

<b>NAME ON BANK ACCOUNT (REQUIRED)</b>			
<b>ACCOUNT TYPE (REQUIRED)</b> <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS			
<b>BANK NAME (REQUIRED)</b>		<b>BRANCH NAME (REQUIRED)</b>	
<b>COMPLETE BANK ADDRESS (REQUIRED)</b> Address1 Address2 City, St, ZIP		<b>BANK PHONE NUMBER (REQUIRED)</b>	
<b>ACCOUNT NUMBER (REQUIRED)</b> Must match letter or voided Check		<b>TRANSIT/ABA NUMBER (REQUIRED)</b> Must match letter or voided Check	

**An authorized signer on the bank account must sign this form**  
***This is a legal document.***

<b>PRINT NAME: (REQUIRED)</b>	_____	<b>SIGNATURE: (REQUIRED)</b>	_____
<b>TITLE: (REQUIRED)</b>	_____	<b>PHONE NUMBER: (REQUIRED)</b>	_____
<b>DATE SIGNED: (REQUIRED)</b>	_____	<b>FAX NUMBER:</b>	_____

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**ATTACHMENT B**