

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 Remittance Advice (ERA)
 Provider Registration Request and Cancel Form
 CARITEN HEALTH - 62073

Instructions to Provider:

- A. Please complete this form {Steps (1), (2) & (3)} if requesting to register to receive or to cancel an Electronic Remittance Advice (ERA) from Cariten Health.**
- B. E-mail the completed form to your clearinghouse. (Note: your clearinghouse will forward the registration request/change to Cariten Health.)**
- C. Retain a copy for your records.**

(1) Action Requested

(2) Effective Date:

Select one:	<input type="checkbox"/> Enroll for ERA (Note: Explanation of Payments currently provided will continue.)	<input type="checkbox"/> Cancel ERA (Note: For any reason, including change in Clearinghouse.)	Indicate the ERA Effective Date or Cancel Date requested. (specify date – mm/dd/yyyy) (Note: Future Date only.)
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(3) Provider Information (Use for solo practitioners, groups, facilities, ancillary providers, etc.):

Provider Type:	<input type="checkbox"/> Medical	<input type="checkbox"/> Dental	<input type="checkbox"/> Both
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<ul style="list-style-type: none"> • TIN # (To which payment will be made) • TIN# Type (indicate SSN or EIN) • TIN (Tax ID) name on W9 	<ul style="list-style-type: none"> • Solo Practitioner First/Last Name and Degree, • Group Name, (if applicable) • Facility Name or • Ancillary Name 	
Billing Address: <ul style="list-style-type: none"> • Street/P.O. Box • City • State • Zip 	For Facilities: <ul style="list-style-type: none"> • Type of facility (e.g., hospital, hospice, skilled nursing, etc.) For Ancillary: <ul style="list-style-type: none"> • Type of ancillary (e.g., DME, lab, mental health, etc.) 	
E-mail address	Fax #	
Phone #	Contact Name:	

(4) Clearinghouse Information (completed by clearinghouse):

Clearinghouse ID#		Clearinghouse Name:	Emdeon
Phone #	800-845-6592	Fax #	615-885-3713
<ul style="list-style-type: none"> • E-mail address and • Contact Name 	Payerregistration@emdeon.com	Date Request Completed	
Covenant Health Internal Use Only:	Date Request Received:		

Notes:

- a) Provider records will be updated within 14 business days of receipt of this form by Covenant Health.
- b) ERAs will be produced beginning the first payment date after the ERA effective date:
 - For claims received after the ERA effective date
 - For claims received before the ERA effective date, if processed and consolidated on the same check with claims received after the ERA effective date.
 Note that the "ERA effective date" is the date requested or the current date at the time the registration request is processed by Covenant Health, whichever is later. Retroactive dates are not accommodated.
- c) ERA election will be effective for all practitioners registered within the same TIN#.
- d) Explanation of Payments (currently provided) will continue to be produced.