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 *(Emdeon certified vendor used to submit files to Emdeon)*

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:

- All Payer Registration forms must contain original signatures, no stamped signatures or photocopies are accepted.

- SUBMIT COMPLETED FORM TO:
  Emdeon
  Donelson Corporate Ctr Bldg 3
  3055 Lebanon Pike Ste 1000
  NASHVILLE, TN 37214-2230

EMDEON REVISION FORM DATE:

835 Remittance - Electronic Explanation of Claim Payment
Provider Enrollment Form

SECTION I: Provider Information

Practice/ Facility Name:	NPI Type II: **(required)**
Primary Physical Address:	
Contact Person:	
Practice/Facility Contact Person e-mail address: **(required)**	
Practice/Facility Telephone #:	Practice/Facility Tax ID#: **(required)**

SECTION II: Type of Transaction requested (select only one and fill out the corresponding information)

☐ **Direct** Complete only section **A.**

☐ **Clearinghouse** Complete only section **B**.

Section A. Direct Transaction

For a direct transaction all the following must be reviewed and answered:

1. What client FTP access protocol will you be using? [We support HTTPS (any web browser), FTPS (FTP + SSL) and SFTP (SSH access)].

   ____

2. What client FTP software will you be using?

   ____

3. We will PGP encrypt all outgoing files. Will you be able to provide your PGP public key (we will request this in via email at a future time)? ☐ Yes or ☐ No

Please provide:

Technical contact name: ______________________________

Email address: ______________________________

Phone number: ______________________________

If you are unable to provide all the information requested in this section a direct transmission may not be your best option.

Section B. Clearinghouse Information

Choose one of the following clearinghouses:

☐ **P N C Bank** (preferred)

☐ **Siemens**

☐ **CPSI**

☐ **Emdeon**

Please note that we will only transmit to these clearinghouses. If you utilize a different clearinghouse have them contact one of the above clearinghouses we utilize to receive your 835 transaction.

By signing below you authorize Geisinger Health Plan and it's affiliates to release our claim payment information to the marked clearinghouse in an electronic HIPAA compliant 835 transaction.

Authorized Signature: ______________________________

Print Name: ______________________________

Title: ______________________________

Date: ______________________________

Form can be faxed to 570-271-5297 – **Prior to final set up original signature page must be returned to**:
Geisinger Health Plan, Dept 32-20, 100 North Academy Avenue, Danville Pa 17822-3022

Instructions:
1. This letter must be typed on the provider's original **letterhead.**
2. Fill in information in the parentheses as it pertains to you. For group practices, be sure to include the group information **as well as** a list of each individual provider within the group and their individual id numbers.

(Provider's Letterhead)

(Date)

Geisinger Health Plan

835 ERA Enrollment:

Please consider this letter a confirmation that (**"Facility Name" "NPI"**) authorizes electronic remittance through **Emdeon.**

For questions please contact
"Facility Contact Name"
"Facility Contact Phone Number"
"Facility Email Address"

Sincerely,
(Provider/Facility Authorized Signature)

*****SAMPLE ONLY*****