

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:					



EFT and/or ERA Authorization Form

Rev. 10/14/05

Type of Transaction (please choose)

- Add ERA and EFT Change ERA Terminate ERA and EFT
 Change EFT

Physician Group Notes:

- You need only fill out one EFT and/or ERA Authorization form per Tax ID as long as all the providers in the group have the same bank account.
- Please attach a list of the provider IDs, at the payee entity level, for whom you wish the Authorization to apply

Provider/Physician Name (please print)

Healthfirst Provider ID Number

Federal Employer Identification Number

Provider Type (please choose one)

- Ancillary Hospital Physician Physician Group

I hereby authorize Healthfirst, hereafter called COMPANY, to initiate credit entries and if necessary, adjustments for any credit entries to one of the following accounts indicated below and the depository named below, hereafter called DEPOSITORY, to credit the same to such account.

Account Type (please choose one if you wish to participate in the EFT process)

- Checking Savings Demand Deposit Money Market

Account Name

Depository/Bank Name (please print)

Address (please print)

City

State

Zip

Phone

Please include a deposit slip/cancelled check if you wish to participate in EFT.

Routing Number

Account Number

If you wish to participate in our **ERA** process, please identify which Clearing House you (or your vendor) are currently using. Please note that you or your vendor must use one of the clearing houses in order to participate in our ERA process.

- Emdeon I-UB92 Emdeon P-HCFA 1500 Other: Name _____

This authority is to remain in full force and effect until COMPANY has received written notification from me of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on said notice of termination. Provider agrees that all ERA and/or EFT transactions will be conducted in accordance with company's policies and procedures (and may be changed from time to time) and may be suspended or discontinued at any time.

Special ERA/Paper Remittance Note

- I wish to receive ERA only.

Please note: At the conclusion of the trial period, paper remits will no longer be available.

Name (please print)

Title

Signature

Date

Please provide the name of a contact person that can verify and provide any changes in the above listed data.

Contact Name (please print)

Title

Phone Number

Email Address

Address

City

State

Zip

Please direct questions and/or fax, mail or e-mail this form as follows:

Phone: 888-801-1660

Mail: Provider Services, P.O. Box 5168, New York, NY 10274-5168

Fax: 646-313-4635

E-Mail: hfprovsrvs@healthfirst.org

www.healthfirstny.com