

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		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		Receiver 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:	
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**Special Instructions:**

- All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.
- SUBMIT COMPLETED FORM TO:
  - Fax: (615) 231-4843
  - E-mail: [batchenrollment@Emdeon.com](mailto:batchenrollment@Emdeon.com)

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REVISED DATE:



# Group/Provider Access Information for 835 Transaction Set

Date: \_\_\_\_\_ Please Provide Current UserID(e.g SFT0001) \_\_\_\_\_

**Section I** Please complete a separate form for each Group and Provider number receiving a reimbursement voucher. (Information should be obtained from your most recent reimbursement voucher, see sample below)

Billing National Provider ID# (NPI): \_\_\_\_\_ (Required)

(1) CDPHP's Group or Provider number: \_\_\_\_\_

(2) Tax ID of Group/Provider: \_\_\_\_\_

Voucher/Remit Name and Address (Please print or type)

(3) Group/Provider Name: \_\_\_\_\_

(4)Address 1: \_\_\_\_\_

(5)Address 2: \_\_\_\_\_

(6)City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

CAPITAL DISTRICT PHYSICIANS' HEALTH PLAN, INC. (CDPHP) PATROON CREEK CORPORATE CENTER 500 PATROON CREEK BLVD. ALBANY, NEW YORK 12206-1057	<b>PAYMENT VOUCHER</b>
<p>3 Group/Provider Name</p> <p>4 Group/Provider Address 1</p> <p>5 Group/Provider Address 2</p> <p>6 Group/Provider City, State Zip</p>	DATE: _____ PAGE: TIN: <b>2</b> P 99999999 or CHECK # G 9999 <b>1</b> AMOUNT: _____
	<b>FOR TELEPHONE INQUIRIES CALL:</b> (518) 641.3500

## Section II

Contact Information (Provider office contact)

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

Telephone: \_\_\_\_\_ Ext.: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Address 1: \_\_\_\_\_

Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

**Section III**

## Technical Contact Information (Vendor Contact details)

Technical Contact Name: ENROLLMENT HELP DESK Title: \_\_\_\_\_  
Telephone: 800-845-6592 Ext.: \_\_\_\_\_ Fax: 615-231-4843  
E-mail Address: payerregistration@emdeon.com  
Address 1: 26 CENTURY BLVD STE 601  
Address 2: \_\_\_\_\_  
City: NASHVILLE State: TN Zip Code: 37214

Complete the following only if you will have a 3<sup>rd</sup> party vendor retrieving your 835 transactions from CDPHP:

I authorize EMDEON to act as my agent to view Capital District Physicians' Health Plan, Inc. (CDPHP), Capital District Physicians' Healthcare Network, Inc. (CDPHN) or CDPHP Universal Benefits, Inc. (UBI) member data, including possible protect health information (PHI) in any format deemed appropriate by CDPHP, CDPHN or UBI, on my behalf. The entity listed above is my authorized business associate. I authorize the entity listed above to receive correspondence related to the submittal and processing of ANSI X12 835 transactions on my behalf.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_ Employer: \_\_\_\_\_

The NPI number should be the group practice's billing NPI, facility billing NPI, or individual practitioner NPI if a sole practitioner.

Please fax or mail to:

CDPHP  
Network Services department  
500 Patroon Creek Blvd.  
Albany, NY 12206  
FAX#: 518-641-3209

If you have connectivity questions, please contact the [EDI\\_Team@cdphp.com](mailto:EDI_Team@cdphp.com) or 518-641-4EDI(4334).

If you have questions concerning Section I through III, please contact Provider Services:

Capital area @ (518) 641-3500 or 1-800-926-7526, Central region @ 1-877-260-0512, Hudson Valley region @ 1-877-260-0801.