

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

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REVISED DATE:

Medicare Part B Electronic Remittance Advice (ERA) Request Form

Note: Please allow 10 days for processing and an additional 3–5 business days for notification via mail.

Provider Name and Address: *** Provider Information Required ***		Receiving Name and Address: Address of clearinghouse, vendor or billing agency downloading and processing ERA data. *** Not required if provider does his own download. ***	
		EMDEON	
		26 CENTURY BLVD STE 601	
		NASHVILLE TN 37214	
E-mail Address:		E-mail Address:	payerregistration@emdeon.com
Existing ERA Receiver Number:	EJ41293		
Contact Person (Full Name):	JAMES CARNEY		
Is this a new contact name?	<input checked="" type="checkbox"/> Yes	<input type="checkbox"/> No	
Phone Number:	(800) 845-6592	Fax Number:	(615) 231-4843
Type of Remittance: MAILBOX (GPNet):	<input type="checkbox"/> Zipped	<input checked="" type="checkbox"/> Unzipped	
Format: ANSIX12 835 version 004010X091A1			
Provider Number:		NPI Number:	
*** Group, solo or organization number only. Do not list group member numbers. ***			

If the provider downloads and processes his own ERA data, signing this form certifies he will not share his receiver number and password with any other entity. If remittance is to be provided to a clearinghouse, software vendor or billing agency, the provider's signature signifies approval for them to do the download.

Provider Signature: _____
(Or representative legally empowered to sign this form on behalf of the provider name identified on this form.)

Mail or fax this form to:

TrailBlazer Health Enterprises, LLC
P.O. Box 660156
Dallas, TX 75266-0156
Fax: (469) 372-1045