

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
Electronic Data Interchange

**General Completion Instructions for
Electronic Data Request (EDR) Form**

The Electronic Data Request (EDR) Form is designed for Medicare providers to apply for or revise existing information pertaining to the Electronic Remittance Advice (ERA) or the Electronic Claim Status (ECS) Request and Response transaction. **Prior to applying for one of these transactions, check with your software support vendor to ensure you have the necessary software to conduct the transaction.**

Please review the following completion instructions carefully to ensure all required information is provided. If all required information is not provided, the form will be returned to the sender/submitter for the additional information.

SECTION A: Request Type. This section is required.

New Sender/Submitter: If you do not have a sender/submitter number to transmit or receive electronically, a New Installation/Change of Vendor Form is required prior to being set up to receive electronic remittances or electronic claim status. You may submit this form (EDR) with the New Installation/Change of Vendor Form. Indicate in this section which transaction you are applying for.

Existing Sender/Submitter: If you currently have a sender/submitter number, indicate which transaction you want to add or delete. Please note the PC-ACE Pro32® software does not support the electronic claim status transaction.

SECTION B: Sender/Submitter Information. All fields in this section are required unless otherwise indicated as optional or conditional.

The sender/submitter information refers to the entity that will conduct the electronic exchange of the transaction. Third party billers need to apply for their own sender/submitter number. **A third party biller cannot use a Medicare Provider's assigned Sender/Submitter number.**

Sender/Submitter Number (Conditional): Indicate the sender/submitter number that will be used to transmit or receive electronic transactions. Required when adding a transaction to or deleting a transaction from an existing sender/submitter number.

Sender/Submitter Name: Indicate the name of the sender/submitter.

Mailing Address: Indicate the address of the sender/submitter.

City/State/Zip: Indicate the city, state and zip for the sender/submitter's address indicated above.

Contact Name/Position or Title: Indicate the name and title of the person to be contacted in case of inquiries concerning this form.

Telephone: Indicate the telephone number of the sender/submitter in case of inquires concerning this form.

Fax/Email Address (Optional): Indicate the fax number and email address of the sender/submitter in case of inquires concerning this form.

SECTION C: VENDOR INFORMATION. All fields in this section are required unless otherwise indicated as optional.

Vendor Name: Indicate the software support vendor's name.

Vendor Address (Optional): Indicate the software support vendor's address.

City/State/Zip (Optional): Indicate the software support vendor's city, state and zip for the address as shown above.

Contact Name/Position/Title (Optional): Indicate the name and title of the contact person for the software support vendor.

Telephone and Fax Number (Optional): Indicate the contact person's telephone and fax number.

SECTION D: DEFAULT DELIMITERS (Optional): Please contact your software support vendor for information about the default delimiters. If your software supports the default delimiters, please leave blank. If you are using the PC-ACE Pro32® software, leave blank.

SECTION E: Signature, Title, Provider's Name and Medicare Provider Number (if known), Effective Date, National Provider Identifier (NPI), Provider's Tax Identification Number / Social Security Number. All fields in this section are required.

The signature of the provider or authorized party for the provider is required. Indicate the title of the provider or authorized party, Medicare billing provider's name, Medicare provider number (if known), the effective date, the billing provider's NPI (if the provider is a member of a group indicate the group's NPI), the billing provider's Tax Identification Number / Social Security Number.

NOTE: When the provider is using a third party, e.g., clearinghouse, billing service, etc., to exchange EDI transactions, the signature serves as the provider's authorization for that third party to act on behalf of the provider for the indicated EDI transaction(s). The provider is required to have on file, an agreement signed by the third party in which the third party has agreed to meet the same Medicare security and privacy requirements that apply to the provider in regard to viewing or use of Medicare beneficiary data. **A representative from a billing service or clearinghouse is not authorized to sign on behalf of the provider.**

You may fax your Electronic Data Request Form for processing. However, if the provider does not have an EDI Enrollment Form on file, please submit the Electronic Data Request form with the signed EDI Enrollment Form. Failure to have an EDI Enrollment form on file will result in the EDR form being returned.

FAX OR MAIL COMPLETED FORMS TO:

Mailing Address:

Medicare EDI
PO Box 44071 – 14T
Jacksonville, FL 32231-4071

Telephone and Fax Numbers:

FL (904) 791-8767, option 2
CT (203) 639-3160, option 1
Fax (904) 791-6692

Physical Address:

Medicare EDI
532 Riverside Ave. 14T
Jacksonville, FL 32202-4918

****Attention: The provider is required to notify Medicare EDI, in writing, in advance of any changes impacting their use of EDI and the effective date of such changes. Medicare EDI must be notified if the provider will begin, change, or discontinue using a billing service, clearinghouse, or other third party. The form necessary to notify us of such changes is the EMC Change of Information form that can be downloaded from the Web site www.fcso.com. Select Medicare Electronic Services-Using EDI-Forms.**

If you have questions about the completion of this form, please refer to the "General Completion Instructions" of the EDR form.

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PO Box 44071 – 14T
Jacksonville, FL 32231-4071

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