

PAYER ID:

SUBMITTER ID:



## Emdeon ERA Provider Information Form

\*This form is to ensure accuracy in updating the appropriate account

<b>1 Provider Organization</b>					
Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
<b>2 Vendor</b> <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					
<b>3 Payer</b>					
Payer ID					
Group ID	Individual Provider ID		NPI ID		
<b>4 Confirmations</b>					
Send Emdeon Claim Confirmations To:					
Special Instructions:					
<ul style="list-style-type: none"> <li>All Payer Registration forms must contain signatures when applicable, stamped signatures or photocopies are accepted.</li> <li>SUBMIT COMPLETED FORM TO:            Fax: (615) 231-4843            Email: <a href="mailto:batchenrollment@Emdeon.com">batchenrollment@Emdeon.com</a></li> </ul>					
EMDEON REVISION FORM DATE:					

# ABCBS Electronic Remittance Advice Request Form (ERA/835)

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## Provider Information

Submitter Number of Provider/Group: \_\_\_\_\_  
Submitter Number *picking up the remittance advice*: E6137 \_\_\_\_\_  
Effective Date: \_\_\_\_\_  
Provider Name: (Hospital, Clinic, or P.A. Group): \_\_\_\_\_  
Group PTAN/Pay-to Provider Number: \_\_\_\_\_  
Group/Pay-to NPI Number: \_\_\_\_\_  
Address 1: \_\_\_\_\_  
Address 2: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Contact Person's Name: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Fax Number: \_\_\_\_\_  
Email Address: \_\_\_\_\_

### Indicate Professional or Institutional For ERA (ANSI 835/ERA) Transaction:

- Private Business (ABCBS) Professional  
 Private Business (ABCBS) Institutional

**Only one submitter ID per provider number may be established for ERA. This means the submitter ID on this request will be the only recipient of ERA for the provider number(s) listed. All others will be discontinued.**

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Provider's Authorized signature

Title

Date

**Authorized signature of the provider is one who is authorized to sign legal documents on behalf of the provider. Signatures from the billing service or clearinghouse are not accepted.**

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### RETURN ADDRESS:

Medicare EDI Services EDI 4-BC/S  
P.O. Box 2181  
Little Rock, AR 72203-2181  
FedEX or UPS: 601 S. Gaines St. Little Rock AR. 72201  
Fax: (501) 378-2265  
Service Line: (866) 582-3247 [edi@arkbluecross.com](mailto:edi@arkbluecross.com)