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 *(Emdeon certified vendor used to submit files to Emdeon)*

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:

- **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:

835 ERA Customer Information Sheet

Connectivity Type:
Existing Connection? Yes ☒ No ☐ Existing Type:

☐ FTP Batch Only
☐ Socket to Socket RealTime Only
☐ MQ Series Batch ☐ RealTime ☐ Both ☐
☐ Tumbleweed Batch Only

New Customer ☐ Existing Customer ☒ Sender ID 0056H

ERA RECEIVER INFORMATION:

Receiver Name: EmDeon
Physical Address: 26 Century Blvd., #600 City: Nashville State: TN Zip: 37214

Mailing Address: _____ City: _____ State: _____ Zip: _____

ERA Contact Name: Christy Gosnell Alt. Contact: _____

Contact Phone Number: (615) 231-4947 Fax Number: _____

Contact E-mail Address: Cgosnell@emdeon.com

****Please Note: Once in production for the 835, Blue Cross Blue Shield of AZ will no longer issue paper remittance advice.***

****
Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only
Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S
Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

****
Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only
Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S
Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

****
Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only
Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S
Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

835 ERA Customer Information Sheet

Additional Provider Forms

Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only

Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S

Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

****

Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only

Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S

Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

****

Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only

Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S

Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

****

Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only

Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S

Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

****

Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only

Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S

Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

****

Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only

Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S

Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

835 ERA Customer Information Sheet

Additional Provider Forms

Physician or Facility Name:

Tax ID Number:

NPI: Organizational NPI: (if you receive a group remit)

For Internal Use Only

Provider/Group P#: _____ Claims Pay to ID: _____ Pay To ☐P ☐G ☐S

Tax ID Number to be added to the CFR Provider Tax ID Table ☐Y ☐N

****

835 Acknowledgement

I acknowledge that **Emdeon** will be picking up my *835-Electronic Remittance Advice* with E-Commerce Services, a division of Blue Cross Blue Shield of Arizona **Emdeon** has completed initial 835 testing with BCBSAZ and will not be offering individual testing. **Once in production, I will no longer receive a Blue Cross Blue Shield of Arizona (BCBSAZ) paper Remittance Advice.** _____ ***(initial here)***

NAME OF PROVIDER/SITE ______________________________

SIGNATURE ______________________ **DATE** __________

MAILING ADDRESS ______________________________

CITY, STATE, ZIP CODE ______________________________

CONTACT PERSON E-MAIL ______________________________

PROVIDER TAX ID/SOCIAL SECURITY ______________________________

PROVIDER CONTACT PERSON ______________________________

PROVIDER PHONE NUMBER ______________________________

PROVIDER MAILING ADDRESS ______________________________

PROVIDER CITY, STATE, ZIP CODE ______________________________

NPI ______________________________

ORGANIZATIONAL NPI (if group remits) ______________________________

- -

Emdeon______________________________
NAME OF BILLING SERVICE/ CLEARINGHOUSE

____
NAME OF PRACTICE MANAGEMENT SYSTEM VENDOR

MY SYSTEM PROVIDES AN 835 POSTING MODULE PROVIDED BY ABOVE NAMED VENDOR

- ☐ **YES**
- ☐ **NO**

MY SYSTEM PROVIDES AN 835 PRINT TOOL

- ☐ **YES**
- ☐ **NO**

Please sign form and return to eSolutions immediately. This form must be received prior receiving the 835 Electronic Remittance Advice.