

PAYER ID:

SUBMITTER ID:



## Emdeon ERA Provider Information Form

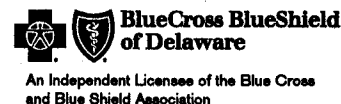
\*This form is to ensure accuracy in updating the appropriate account

<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><b>SUBMIT COMPLETED FORM TO:</b>            Fax: (615) 231-4843            Email: <a href="mailto:batchenrollment@Emdeon.com">batchenrollment@Emdeon.com</a></li> </ul>					
EMDEON REVISION FORM DATE:					



Blue Cross Blue Shield of Delaware • P.O. Box 1991 • Wilmington, DE 19899-1991

Phone: 302 421-8428
Fax: 302 421-8485
E-mail: emc@bcbsde.com
Web Site: www.bcbsde.com



Electronic Data Exchange Enrollment

Provider Name or Group, Provider Number, Address, Contact Person, Telephone, Adding to existing Submitter?, Name of (check one), Address, Contact Person

If you are unable to answer any of the following questions, please contact your hardware/software vendor.

CLAIMS SUBMISSION

Modem Protocol (asynchronous only)

X modem Y modem Z Modern ASCII

Transmission Format

National Standard (NSF) Version:

OTHER SERVICES AVAILABLE (Check those desired.)

Claims Status Eligibility and Benefits Electronic Remittance Advice

In accordance with specifications set forth by Blue Cross Blue Shield of Delaware (The Corporation) for submission of automated claims, I/we agree that:

The Provider agrees to submit claims in accordance with the Participating Contract and in the format specified by The Corporation.

The Corporation agrees to accept and process claims submitted in accordance with this contract. Such processing and payment will be according to the terms of the Participating Provider Contract.

The Provider will ensure that every claim submitted can be readily associated and identified with the patient's medical and business office records. All medical records and source documents will be retained for a period of six (6) years after the month the bill was submitted. These records may be retained on microfilm.

The Provider agrees that the Corporation or its designee will have reasonable access to all documents pertaining to claims submitted via electronic media for the purpose of auditing and confirming the claims information submitted.

The Provider agrees that any overpayments which are discovered and brought to its attention will be refunded within thirty (30) days of the date of notification.

The Provider will research and correct any and all billing discrepancies caused by submission of automated claims.

The Provider/Corporation will maintain the confidentiality of passwords, preventing unauthorized users from committing data security violations with my log-on identification.

Signature of Health Care Professional or Authorized Representative

Title

Type or Print Name

Date

Please mail the signed original to: Blue Cross Blue Shield of DE, Attn: Electronic Claims (4-2-04), P.O. Box 1991, Wilmington, DE 19899.

(Provider's Letterhead)

(Date)

Attention: Andy Rumford

We would like to start receiving Electronic Remittance through the following clearinghouse:

Emdeon  
One-Century Place  
26 Century Blvd, Ste 601  
Nashville, TN 37214  
800-735-8254  
Submitter ID: 582573488

Here is our Provider Information

Provider Name:  
Provider Address:  
Provider Tax ID (9-digits):  
BCBS DE Provider ID:

Sincerely,

(Provider Name & Signature)



## Authorization Agreement for Direct Deposit Transactions

Provider Name: \_\_\_\_\_

Provider Number(s): \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Bank Name: \_\_\_\_\_

Bank ABA Number: \_\_\_\_\_

Checking Account Number: \_\_\_\_\_

Office Contact and Phone Number: \_\_\_\_\_

\_\_\_\_\_

The completion and signing of this form will give Blue Cross Blue Shield of Delaware (BCBSD) authorization to electronically credit the above account, effective within five (5) business days of receipt of the form by BCBSD.

- Please be advised that by completing this form, you are also authorizing BCBSD to electronically debit this account in the event there are overpayments or duplicate payments.
- Please notify us, in writing, if you decide you wish to be removed from the direct deposit credit process. It may take up to five (5) business days after receipt of your request payments to be sent as checks.

Should you have any questions regarding your direct deposit payments, please feel free to contact: **Andy Rumford at 302.421.8428.**

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_

**Mail completed form to:**  
Blue Cross Blue Shield of Delaware  
P.O. Box 1991  
Wilmington, DE 19899-1991  
ATTN: Andy Rumford 5-2-65

**Fax:**  
ATTN: Andy Rumford  
302.421.3265