

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 <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
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:	<ul style="list-style-type: none"> • All Payer Registration forms must contain original signatures, no stamped signatures or photocopies are accepted. • SUBMIT COMPLETED FORM TO: Emdeon Donelson Corporate Ctr Bldg 3 3055 Lebanon Pike Ste 1000 NASHVILLE, TN 37214-2230 				
EMDEON REVISION FORM DATE:					



BLUE CROSS

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835 Claims Payment and Remittance Advice EDI Authorization Form

This Authorization Form is required for the set-up of the 835 Claims Payment and Remittance Advice. An original signature is required. Please return the completed form to the address below:

**Premera Blue Cross
PO Box 327 MS281
Seattle, WA 98111-0327**

Provider or Group/Facility Information:

Name: _____ PBC EDI Submitter ID _____

Address: _____

City: _____ State: _____ Zip: _____

Tax ID: _____

Provider NPI: _____

Do you share this Tax ID with other groups, facilities or individual providers? Yes _____ No _____

If Yes: The 835 transaction will include payments for all providers who share this Tax ID and will be sent to the Submitter ID specified below. The Paper vouchers with checks are not affected.

PBC, EDI Submitter ID of the office that will receive the 835 transaction: AC005

Clearinghouse/Billing Service Information:

Name: EMDEON Current PBC Submitter ID AC005

Address: 3055 LEBANON ROAD BLDG 3 STE 2000

City: NASHVILLE State: TN Zip: 37214

Phone: 800-845-6592 Fax: 615-231-4843 Email Address: PAYERREGISTRATION@EMDEON.COM

Contact Name: ENROLLMENT HELP DESK

I authorize the above named Clearinghouse/Billing Service to receive the 835 Health Care Claim Payment Advice on my behalf.

Provider Signature: _____ **Date:** _____

Please note, should the exchange relationship between this provider and billing agent change, immediately contact the EDI Team at 1-800-435-2715, option 1, or at edi@premera.com