

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 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:					

Instructions:

1. This letter must be typed on the provider's original **letterhead**.
2. Fill in information in the parentheses as it pertains to you. For group practices, be sure to include the group information **as well as** a list of each individual provider within the group and their individual id numbers.

(Provider's Letterhead)

(Date)

Attention HMSA

835 ERA Enrollment:

Please consider this letter a confirmation that (“**Facility Name**” “**NPI**” “**Payer Assigned Submitter ID**”) authorizes electronic remittance through **Emdeon – Trading Partner #WebMD1**. For questions please contact “**Facility Contact Name**” “**Facility Contact Phone Number**”

Sincerely,
(Provider's Signature)