

PAYER ID:

SUBMITTER ID:



emdeon™

## 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 original signatures, no stamped signatures or photocopies are accepted.</li> <li>• SUBMIT COMPLETED FORM TO:  Emdeon  Donelson Corporate Ctr Bldg 3  3055 Lebanon Pike Ste 1000  NASHVILLE, TN 37214-2230</li> </ul>					
EMDEON REVISION FORM DATE:					



# First Health Services Corporation

## Provider Electronic Remittance (835) Authorization

Alaska Medical Assistance is capable of sending an 835 transaction to a single entity/organization only. The purpose of this form is to allow providers to designate who should receive their 835. Please complete the following form for this designation and indicate all Alaska Medical Assistance provider numbers that are applicable.

### Send my 835 to:

- Self (practice management software able to receive)
- Billing Agent
- Clearinghouse
- Other

Organization Name: WebMD

Contact Name: Enrollment Help Desk

Phone Number: 1-800-845-6592

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

Alaska Medical Assistance Provider ID Number(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone #: \_\_\_\_\_

I authorize the above named entity to receive and process my electronic remittances (835) from Alaska Medical Assistance Programs. I may have multiple entities submitting claims for me and understand that only one entity can be designated by me to accept and process my electronic remittance. I also understand that the entity I have authorized above must have prior approval from First Health Services to receive electronic remittances.

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**Print Authorized Representative Name**

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**Title Authorized Representative**

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**Signature of Provider\* or Authorized Representative\*\***

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**Date**

*\* Individuals and sole proprietors must sign their own enrollment agreement form.*

*\*\*An authorized representative is an appointed official to whom the provider has granted the legal authority to enroll the provider in the Medicaid program, to make changes and/or updates to the provider's status in the Medicaid program (e.g., new practice locations, changes of address, etc.), and to commit the provider to fully abide by the laws, regulations, and program instructions of the Medicaid program. The authorized official must be the provider's general partner, chairman of the board, chief financial officer, chief executive officer, president, direct owner of 5% or more of the provider's organization, or must hold a position of similar status and authority within the provider's organization.*

*If you fax this document, please be sure to mail the original.*

**Mail Original or Fax to:** First Health Services Corporation  
HIPAA Provider Support Team  
P.O. Box 240808  
Anchorage, Alaska 99524-0808

Fax Number: (907) 644-8126