

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:					
<p>Special Instructions:</p> <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 					
THE NPI NUMBER MUST ALSO BE ADDED WEHRE PROVIDER ID IS INDICATED					
EMDEON REVISION FORM DATE:					

Exhibit B

PROVIDER RELEASE AUTHORIZATION

This release is submitted to EDS as authorization to forward Medi-Cal Supplemental Claims Payment Information (SCPI) on computer media directly to the designated agent listed below and/or in Section I of the Medi-Cal Supplemental Claims Payment Information (SCPI) Enrollment, for the purposes of Medi-Cal billing, collection and/or reconciliation services.

SCPI Receiver Number 2E5
 Contact Person ENROLLMENT
 Phone Number 866-924-4634
 Provider Name WebMD/Envoy DBA EMDEON
 Provider Address 3055 Lebanon Pike, Suite 1000
 City NASHVILLE State TN Zip 37214

Please enter the complete nine or 10-digit provider number along with the last four digits of their Federal Tax ID Number (TIN) for each provider that you are requesting to receive SCPI records for the receiver listed above.

Note: "NO" is the default value for receiving paper RAD and Medicare "no-pay" crossover data records. By selecting "NO" for paper RAD, the provider will not receive paper RAD from the State Controllers Office. If the provider wishes to continue to receive their paper RAD data, select option "YES" below.

Provider number and last four digits of TIN	Provider Name	Receive Paper RAD? ___(NO)___YES	Receive Medicare "No-Pay" Records? ___(NO)___YES
_____	_____	___(NO)___YES	___(NO)___YES
_____	_____	___(NO)___YES	___(NO)___YES
_____	_____	___(NO)___YES	___(NO)___YES
_____	_____	___(NO)___YES	___(NO)___YES
_____	_____	___(NO)___YES	___(NO)___YES
_____	_____	___(NO)___YES	___(NO)___YES
_____	_____	___(NO)___YES	___(NO)___YES
_____	_____	___(NO)___YES	___(NO)___YES
_____	_____	___(NO)___YES	___(NO)___YES

I certify by signing this release that I am authorized to sign on behalf of the provider specified, and to the best of my knowledge and belief the information furnished is correct. Furthermore, I agree to notify EDS, in writing, should any change to the information provided above occur.

Authorized Signature: _____ Title: _____

Print Name: _____ Date: _____

Return Agreement To:
 EDS
 Attn: SCPI Operations
 3215 Prospect Park Drive, RM 270
 Rancho Cordova, CA 95670