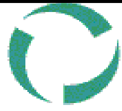
PAYER ID: SUBMITTER ID:



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 *(Emdeon certified vendor used to submit files to Emdeon)*

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:

- 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:

ACS EDI Update Form

ACS EDI Gateway, Inc.

1-800-987-6715

www.acs-gcro.com

A. IDENTIFICATION INFORMATION

Please indicate your Provider/Business name:

Please indicate your provider ID (if applicable)**:** **This number consists of 9 numeric digits and 1-2 alpha characters**

Please indicate your ACS EDI Trading Partner ID (if applicable)**:**
(Your trading partner ID was issued to you at the time of enrollment with ACS EDI. You may find this ID on your ACS EDI Logon/Welcome form.)

A trading partner ID could range from 3-8 digits

B. CONTACT INFORMATION

Please indicate a contact person for your business. (*This should be the person to contact if we have questions concerning this request?*)

Contact individual:	*First name:*	*Last name:*
Contact phone #:		**Contact fax #:**

C. SPECIAL REQUEST

Please select the option that best fits your request and sign below in section D. *(Check all that apply)*

❑ I am no longer interested in being a trading partner with ACS EDI Gateway, Inc. Please discontinue my trading partner profile. My ACS Gateway logon user name and user ID are as follows:

User name: User ID:

❑ I wish to change my relationship with my current **Billing Agent/Clearinghouse** as indicated below:

Action	*Provider Name*	*Provider Number*	*Transaction Types (i.e.: 997, 835, 837, or ALL)*	*Trading Partner ID*
☐ Remove			835	100548
☐ Add			835	100548

(You may attach an additional sheet if necessary)

❑ Other:

____

____

____

____

____

D. PLEASE SIGN AND DATE BELOW *(required)*

Requester name *(please print)*: ______________________________

Signature of requester: ______________________________ Date: ____________________

Please return completed form to:

Fax #: 1-866-309-0935
or mail to:
ACS
Attn: EDI Enrollment Unit
PO BOX 4000
McRae, GA 31055

POWER OF ATTORNEY FOR ELECTRONIC CLAIMS SUBMISSION

KNOW ALL MEN BY THESE PRESENTS, THAT:

Provider, ____(*Provider's Name*),

with Provider Number____*(Provider Number)*

hereby appoints EMDEON ____*(Name of Billing Service),*

100548 ______________(*Billing Service Trading Partner ID*) as attorney-in-fact for the benefit of Provider,

and in Provider's name, place and stead for the following purposes:

To act as billing service for Provider in submitting Provider's medical assistance claims by Computer Media Input to the Department of Community Health, Division of Medical Assistance (the "Department"), for reimbursement of Provider under the Title XIX ("Medicaid") program in Georgia;

To act as Provider's authorized agent for purposes of signing, on behalf of Provider, the certification statement herein in connection with each Computer Media Input submission of medical assistance claims:

> **"I hereby certify that all information contained on and submitted by Computer Media Input is true, accurate, and complete, and that to the best of my knowledge, information and belief, the services for which medical assistance was sought, in fact, have been rendered by Provider as claimed. Furthermore, I understand and acknowledge that the Department will rely on this certification in the payment of medical assistance, which payment will be made from State and Federal funds, and that the submission of any false claims, information, or documents or the concealment of any material facts is a crime under Federal and State laws."**

To maintain all original source documents for six (6) years following the month of payment, and to ensure that every electronic entry can be associated and identified with a source document.

Provider agrees that the billing service is not an individual or organization, such as a collection agency or service bureau, that advances money based on future Medicaid payments (accounts receivable) due to Provider after agreeing to sell, transfer or assign such rights to payment to the individual or organization for an added fee or a percentage of the accounts receivable.

Provider understands that the granting of this Power of Attorney in no way limits or discharges the ultimate responsibility and liability of Provider for the truthfulness, completeness and accuracy of any and all medical assistance claims submitted by the appointed billing service, and in no way forecloses the application of penalties that may be accessed under the False Claims Act and other applicable federal and state laws.

IN WITNESS WHEREOF, Provider has affixed Provider's seal by the hand of one authorized to act on Provider's behalf.
This ___________ day of ______________________, in the year ________.

____
Printed Name of Enrolled Provider

By: ____
Signature of Provider or Authorized Representative

____
Title of Authorized Representative

Sworn to and subscribed before me
this __________ day of _____________________, in the year ________.

____
(Notary Public)
My Commission expires: _______________________