

PAYER ID:

SUBMITTER ID:



emdeon™

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 					
INSTITUTIONAL ERA 12K07 IS PROCESSED THROUGH THE PROFESSIONAL PAYER ID SKID0 PLEASE MAKE SURE YOU RE SETUP AT EMDEON WITH SKID0 TO RECEIVE ERA FOR 12K07.					
EMDEON REVISION FORM DATE:					

Idaho Medicaid Program Electronic Remittance Advice (ERA) Authorization

The Idaho Department of Health and Welfare (DHW) has adopted the American National Standards Institute (ASC X12N 835 4010A1), Accredited Standards Committee (ASC) X12N Health Care Claim Payment/Advice (ANSI 835) as the standard format for the electronic data interchange (EDI) of Medicaid claim payment data for Medicaid services. ERAs will be made available to the authorizing provider or his agent in the ANSI 835 format on the Idaho Bulletin Board System (BBS). The implementation guide for ANSI transaction (835) are available at www.wpc-edi.com. A provider may elect to receive both a paper and an electronic remittance advice.

I, (Print Name) _____ understand the electronic remittance advice contain similar financial information as paper RAs.

Signature: _____ Date: _____

Provider Address: _____

City: _____ State: _____ Zip: _____

Phone: (____) _____ BBS ID (Required): 445241151

Provider Number(s): _____

Electronic RA only _____ Both a paper and electronic RA _____

I, (Print Name) _____ hereby certify that the billing service or VAN listed below is authorized to receive an electronic remittance advice on my behalf. I agree that if the billing arrangement with the identity listed below is terminated, I will immediately report that termination in writing to EDS.

Signature: _____ Date: _____

Name: EMDEON BUSINESS SERVICES

Address: 3055 LEBANON RD SUITE 201

City: NASHVILLE State: TN Zip: 37214

Phone: (800) 845-6592 Contact: ENROLLMENT HELP DESK

Please return to:

EDS
Attention: EDI TEAM
P. O. Box 23
Boise, ID 83707
1-800-685-3757
FAX 208-395-2198