

PAYER ID:

SUBMITTER ID:



## 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 signatures when applicable, stamped signatures or photocopies are accepted.</li> <li>SUBMIT COMPLETED FORM TO:            Fax: (615) 231-4843            Email: <a href="mailto:batchenrollment@Emdeon.com">batchenrollment@Emdeon.com</a></li> </ul>					
EMDEON REVISION FORM DATE:					



# Electronic Claims Sender Request Form

Please fax the completed form to (716) 929-1062. Please contact the E-Commerce call center at (716) 635-3911 if you have any questions.

**Please indicate reason for test submission:**

New EDI Submitter     Software Vendor Change     Other: \_\_\_\_\_

**Please indicate the transaction(s) you would like to exchange:**

ANSI 837 Institutional     ANSI 837 Professional     ANSI 837 Dental     ANSI 835 Remittance

Date of Request: \_\_\_\_\_ Office Practice Name: \_\_\_\_\_

Office Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Office Contact Person: \_\_\_\_\_ Contact Phone Number: \_\_\_\_\_

Fax Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**\*Please fill out an additional request form for each tax identification number\***

Office Tax Identification Number: \_\_\_\_\_

Multiple Offices with same Tax Identification Number:  Yes     No

Multiple Offices with multiple Sender Id's:  Yes     No

NPI Numbers: \_\_\_\_\_

Your Office is:  Par     Non-Par    Your Office is:  Primary     Specialist     Ancillary     Billing Service

Will your office be using a Clearinghouse:  Yes     No

Clearinghouse Name: EMDEON    Clearinghouse Contact: Enrollment Help Desk

Contact Phone Number: 866.924.4634    Contact E-Mail Address: payerregistration@emdeon.com

Practice Management Software: \_\_\_\_\_ Contact Person: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

**\*\*\* Offices must continue sending production claims while testing to avoid timely filing issues.\*\*\***

**\*\*\*Even if that means billing via paper forms. Signing below acknowledges notification of this.\*\*\***

I will continue billing Via:  My old system     Paper

Office Manager's Signature X \_\_\_\_\_

**Test File Requirements:**

1. A minimum submission of ten claims per tax identification number.
2. A sufficient claims sample reflective of routine billing.
3. If there are multiple providers within a group, claims from at least two providers are required.

**\*\*\* Office Use Only \*\*\***

Sender ID: \_\_\_\_\_ Implementation Date: \_\_\_\_\_ Orientation Date: \_\_\_\_\_

Submission Method:  Web Upload     Dial FTP     Internet FTP

S:\EDI\FORMS\ANSI INTAKE FORM 9.28.09