

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:					
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 					
No enrollment is required if provider submits the claims through Emdeon. If the customer is a ERA only customer then they must complete the attach form.					
EMDEON REVISION FORM DATE:					

Provider Service Center Authorization

Please review and check the block(s) which pertain to you:

Electronic remittance request (835):

I certify that I have authorized Service Center 1473 Emdeon to receive my electronic remittances (835) and that Service Center must have prior approval from First Health Services to receive such electronic remittances. I also understand that I will continue to receive paper remittances **only** for the time period selected below after the electronic remittances start. **(If no time frame is selected below, the default is 60 days.)**

30 days
 60 days
 90 days
 120 days

I understand that only one service center can accept and process my electronic remittances. In order to facilitate the above, I need to terminate Service Center _____ effective on _____ for my 835s.

Claims Status Request/Response (276/277):

I certify that I have authorized Service Center 1473 Emdeon to submit Claims Status Requests and receive Claims Status Responses to the Department of Medical Assistance Services.

* IF YOU DO NOT QUALIFY FOR A NPI AND ARE REQUESTING A NEW API IN YOUR ENROLLMENT PACKET, LEAVE THE NPI/API NUMBER BLANK AND IT WILL BE FILLED IN BY PROVIDER ENROLLMENT AFTER THE API IS ASSIGNED.

PROVIDER NAME	NPI/API NUMBER
SIGNATURE	DATE
PRINTED NAME	TITLE

Fax to: 1-804-273-6797, or
 Mail Original to:
 First Health Services Corporation
 Electronic Media Claims Coordinator
 Virginia Medicaid Operations
 4300 Cox Road
 Glen Allen, VA 23060
 (800) 924-6741