

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:					

## 835 ERA Customer Information Sheet

Connectivity Type:

Existing Connection? Yes  No  Existing Type:

- FTP Batch Only  
 Socket to Socket RealTime Only  
 MQ Series Batch  RealTime  Both   
 Tumbleweed Batch Only

New Customer  Existing Customer  Sender ID 0056H

### ERA RECEIVER INFORMATION:

Receiver Name: EmDeon

Physical Address: 26 Century Blvd., #600 City: Nashville State: TN Zip: 37214

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

ERA Contact Name: Christy Gosnell Alt. Contact: \_\_\_\_\_

Contact Phone Number: (615) 231-4947 Fax Number: \_\_\_\_\_

Contact E-mail Address: Cgosnell@emdeon.com

***\*Please Note: Once in production for the 835, Blue Cross Blue Shield of AZ will no longer issue paper remittance advice.***

\*\*\*\*\*  
Physician or Facility Name:

Tax ID Number:

NPI: \_\_\_\_\_ Organizational NPI: (if you receive a group remit)

*For Internal Use Only*

Provider/Group P#: \_\_\_\_\_ Claims Pay to ID: \_\_\_\_\_ Pay To P G S

Tax ID Number to be added to the CFR Provider Tax ID Table Y N

\*\*\*\*\*  
Physician or Facility Name:

Tax ID Number:

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Tax ID Number to be added to the CFR Provider Tax ID Table Y N

# 835 ERA Customer Information Sheet

## Additional Provider Forms

Physician or Facility Name:

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NPI: Organizational NPI: (if you receive a group remit)

*For Internal Use Only*

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## 835 Acknowledgement

I acknowledge that **Emdeon** will be picking up my *835-Electronic Remittance Advice* with E-Commerce Services, a division of Blue Cross Blue Shield of Arizona. **Emdeon** has completed initial 835 testing with BCBSAZ and will not be offering individual testing.

**Once in production, I will no longer receive a Blue Cross Blue Shield of Arizona (BCBSAZ) paper Remittance Advice.** \_\_\_\_\_ *(initial here)*

\_\_\_\_\_  
NAME OF PROVIDER/SITE

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
MAILING ADDRESS

\_\_\_\_\_  
CITY, STATE, ZIP CODE

\_\_\_\_\_  
CONTACT PERSON E-MAIL

\_\_\_\_\_  
PROVIDER TAX ID/SOCIAL SECURITY

\_\_\_\_\_  
PROVIDER CONTACT PERSON

\_\_\_\_\_  
PROVIDER PHONE NUMBER

\_\_\_\_\_  
PROVIDER MAILING ADDRESS

\_\_\_\_\_  
PROVIDER CITY, STATE, ZIP CODE

\_\_\_\_\_  
NPI

\_\_\_\_\_  
ORGANIZATIONAL NPI (if group remits)

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**Emdeon**

\_\_\_\_\_  
NAME OF BILLING SERVICE/ CLEARINGHOUSE

\_\_\_\_\_  
NAME OF PRACTICE MANAGEMENT SYSTEM VENDOR

**MY SYSTEM PROVIDES AN 835 POSTING MODULE PROVIDED BY ABOVE NAMED VENDOR**

- YES
- NO

**MY SYSTEM PROVIDES AN 835 PRINT TOOL**

- YES
- NO

Please sign form and return to eSolutions immediately. This form must be received prior receiving the 835 Electronic Remittance Advice.