

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 					
EMDEON REVISION FORM DATE:					

Instructions:

1. **This letter must be typed on Provider's Original Letterhead.**
 2. Fill in the information in the parentheses as it pertains to you.
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(PROVIDER'S LETTERHEAD)

EMDEON AUTHORIZATION LETTER

(DATE)

Emdeon
Attn: EMC Enrollment
316 Summer Street , 3rd Floor
Boston, MA 02210

Dear EMC Enrollment:

Please consider this letter a confirmation that **(Provider's Name, Address and BCBSMA Provider Number)** authorizes **Emdeon** to receive BCBSMA payment information (electronic remittance) electronically.

Sincerely,

(Provider's Signature)

Submitter's ERA Vendor Source Code: 00444PVRM

FACSIMILE TRANSMITTAL SHEET

To: EMC Enrollment

From:

Fax: 617-761-3991

Pages: (including this one)

Phone: 800-266-2206 option 6, option 3

Date:

Re: EMC Enrollment Paperwork

Fax:

Phone:

URGENT

FOR REVIEW

PLEASE COMMENT

PLEASE REPLY

PLEASE RECYCLE

NOTES/COMMENTS:

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