

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 					
EMDEON REVISION FORM DATE:					

Electronic Solutions - Electronic Connectivity Request

Please complete the following form and fax the form to **Electronic Solutions, (919) 765-7101**.
A Connectivity Request form is required for each provider group.

PROVIDER NAME		NATIONAL PROVIDER ID	
CONTACT NAME		TITLE	
MAIL ADDRESS	CITY	STATE	ZIP CODE
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS (REQUIRED)	

VENDOR/CLEARINGHOUSE NAME EMDEON		CONTACT NAME ENROLLMENT HELP DESK		TITLE
MAIL ADDRESS 3055 LEBANON PIKE SUITE 1000	CITY NASHVILLE	STATE TN	ZIP CODE 37214	
PHONE NUMBER 866.924.4634	FAX NUMBER 615.231.4843	EMAIL ADDRESS (REQUIRED) PAYERREGISTRTRTION@EMDEON.COM		

BILLING SERVICE NAME		CONTACT NAME		TITLE
MAIL ADDRESS	CITY	STATE	ZIP CODE	
PHONE NUMBER	FAX NUMBER	EMAIL ADDRESS (REQUIRED)		

Electronic Transactions	Connectivity Mode					Effective Date
	Batch				Real Time	
	HTTPS	FTP (Windows GUI)	FTP (Command Line)	SOAP	SOAP	
Eligibility Inquiry – 270/271						
Claims Inquiry – 276/277						
Auth. & Referral – 278						
Electronic Remit – 835 (Par providers only)		X				
Institutional Claims – 837I						
Professional Claims – 837P						

Mail Box Password (8 characters): _____

Type of Sender: Provider Clearinghouse Billing Service

CAQH/CORE certified: Yes No

Sender/Receiver ID (Federal Tax ID): 521409791

Transaction Flow: From provider site directly to BCBSNC
 From provider site to billing service to BCBSNC
 From provider site to clearinghouse to BCBSNC
 From provider site to billing service to clearinghouse to BCBSNC
 Other – Specify: _____

Date _____ Print Name/Title (Required) _____ Authorized Signature (Required) _____

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**BlueCross BlueShield
of North Carolina**