

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:					



E-Commerce – Pre-installation Sender/Receiver Information

Vendor/Billing Service Information

Vendor/Service Name Emdeon

Primary Contact: Enrollment Help Desk Billing Contact: _____

Address: 3055 Lebanon Rd. Bldg. 3, Suite 2000

City: Nashville State: Tn Zip: 37214

Telephone Number: (1-800-845-6592 Fax: (1-615-231-4843

E-Mail: payerregistration@emdeon.com

Are you an Existing Submitter? Yes / No If yes, what is your BCBSVT Sender ID? _____

Type of Practice:

- Single Physician Practice
- Hospital
- Multi-Physician Practice Billing as a Group
- Multi-Physician Practice Billing Individually
- Hospital-based Physician
- Billing Service
- Clearing House

Individual Providers Billing within a Group or Billing Service

Provider Name	BCBSVT Provider Number	BCBSVT Alpha code

File Information

Type of File: Professional – HCFA1500 Claims Institutional – UB92 Claims
 Both (UB92 & HCFA1500) Claims Remittance Advice

File Format: HCFA1500 X.12 (837) UB92 X.12 (837) Remittance Advice X.12 (835)
 HCFA 1500 X.12 (837) A-1 Addenda

Date Received	Production Date	Submitter ID	Password
FOR BCBSVT USE ONLY			