

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 | | | | | |
| ***ONE ENROLLMENT FORM REQUIRED PER TAX ID/BILLING NPI COMBINATION ADDITIONAL ENROLLMENT IS NOT REQUIRED IF YOU ARE ADDING A PROVIDER TO AN EXISTING TAX ID/BILLING NPI ENROLLMENT*** | | | | | |
| EMDEON REVISION FORM DATE: | | | | | |



Section I:

PRACTICE/FACILITY NAME: _____
 ADDRESS: _____
 CITY: _____ STATE: _____ ZIP: _____

Section II:

835 VENDOR/CLEARINGHOUSE NAME: EMDEON
 CONTACT NAME: KARLA DENNIS BLUE CROSS VENDOR ID: 404

Section III:

Electronic Remittance Notices are formatted in the mandated HIPAA version and will be uploaded by Blue Cross to the specified FTP directory each Monday for the following Thursday’s payment. Remittance files are purged from the FTP server after 45 days.

| | |
|---|--|
| <p style="text-align: center;"><u>Required Information</u></p> <p>Indicate the FTP directory where 835 remittance files should be delivered:</p> <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-left: 100px;">ENVOY002</div> | <p style="text-align: center;"><u>Optional Information</u></p> <p><input type="checkbox"/> Check here if a dial-up connection is needed.</p> <p><i>NOTE: A dial-up connection is not required if the FTP server is accessed through the internet or a frame relay connection.</i></p> |
|---|--|

Section IV:

| PRACTICE/FACILITY NAME | PAYEE NPI* (NPI receiving payment) | TAX ID |
|------------------------|---------------------------------------|--------|
| | | |

***The Payee NPI will be the group NPI if the provider is part of a group or the individual NPI if the provider is a sole practitioner. NOTE: If the provider is part of a group, it is not necessary to enroll the Payee NPI/tax ID combination more than once. All providers will be included in the 835 remittance file if they are associated with the Payee NPI/tax ID combination listed in Section IV.**

Completed form should be faxed to EDI Services at 205 733-7362 or emailed to EDIEnrollment@bcbsal.org.

The undersigned hereby:

- Represents and warrants that he or she has full power and authority to execute this agreement on behalf of the health care provider identified in Section I (Provider) and to bind the Provider to the terms and conditions of this agreement;
- Authorizes Blue Cross and Blue Shield of Alabama (BCBSAL) (1) to disclose protected health information to the business associate identified in Section II (Business Associate); and (2) to return Provider passwords to Business Associate;
- Agrees to notify BCBSAL if the Business Associate changes;
- Agrees that Provider will be responsible for all electronic transactions submitted to BCBSAL by Provider, its employees, and its agents;
- Agrees that BCBSAL has the right to audit and confirm information submitted by or on behalf of Provider and shall have access to all original source documents and medical records related to Provider’s submissions. All incorrect payments shall be adjusted in accordance with BCBSAL guidelines;
- Agrees that Provider will use sufficient security procedures to ensure that all transmissions of documents are authorized and protect all data from improper access; and
- Agrees to establish and maintain procedures and controls so that information concerning Blue Cross subscribers, or any information obtained from Blue Cross, shall not be used by agents, officers, or employees of the billing service except as provided by Blue Cross.

Authorized Representative of Provider

Date