

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:					



BlueCross BlueShield of Illinois
 BlueCross BlueShield of New Mexico
 BlueCross BlueShield of Oklahoma
 BlueCross BlueShield of Texas
 Experience. Wellness. Everywhere.™

Electronic Remittance Advice (ERA) Enrollment Form

Availity, L.L.C. supports the exchange of electronic remittances in the ASC X12 835, version 4010A1 format. The enrollment process establishes an electronic mailbox where Availity® will place the electronic remittance file(s) received from payer(s). The provider's Federal Tax ID is required to establish an ERA Receiver mailbox and also will be used to parse remittance transactions from the payer. The assigned electronic ERA Receiver ID and password will be returned via fax to the contact and fax number provided on the enrollment form.

If you are a Billing Service or Clearinghouse wishing to receive the ERA on behalf of a provider, the provider must complete the enrollment documents authorizing you to retrieve their remittance files, or a copy of the Power of Attorney must be submitted with the enrollment form.

NOTE: The paper Provider Claims Summary (PCS) currently provided by Blue Cross and Blue Shield will be discontinued 30 days from the date you begin receiving the ERA files.

CHANGE AN EXISTING OR ADD A NEW ERA ACCOUNT (SELECT ONE)				
Change an existing ERA Receiver ID		Add a new ERA Receiver ID		
<input type="checkbox"/> I need to add a new payer to my ERA account	<input type="checkbox"/> I want to create a new ERA account			
<input type="checkbox"/> I need to change my ERA account information	<input type="checkbox"/> I want to receive my ERAs in my current Submitter mailbox			
<input type="checkbox"/> I need to delete my ERA account information	<input type="checkbox"/> I am a Uniform Payment Plan (UPP) Provider - IL ONLY			
	<input type="checkbox"/> I need a separate mailbox for my Electronic Payment Summary (EPS) File			
INDICATE WHO WILL RECEIVE THE ERA FILE				
<input type="checkbox"/> Provider <input type="checkbox"/> Billing Service <input checked="" type="checkbox"/> Clearinghouse <input type="checkbox"/> Other (please specify):				
MEDIA TYPE (SELECT ONE)				
<input type="checkbox"/> rEDI-Link Mailbox <input checked="" type="checkbox"/> File Transfer Protocol (FTP)* <input type="checkbox"/> ZIP compression needed? (*FTP enrollment is required for this option. For instructions, visit Availity's Web site at www.availity.com .)				
RECEIVER INFORMATION				
Availity User ID	embcbso07			
Receiver Name	EMDEON			
Receiver Address	3055 LEBANON PIKE STE 1000	City	State	Zip
		NASHVILLE	TN	37214
Contact Name	ENROLLMENT HELP DESK			
Telephone + extension	866.924.4634	Fax Number	615.231.4843	
E-mail Address	PAYERREGISTRATION@EMDEON.COM			
Vendor Name/ID (if applicable)				
PAYER INFORMATION				
Payer Name	<input type="checkbox"/> BCBSIL <input type="checkbox"/> BCBSNM <input checked="" type="checkbox"/> BCBSOK <input type="checkbox"/> BCBSTX			
PROVIDER INFORMATION				
<input type="checkbox"/> Check here if the Provider is the same as the Receiver/Submitter.				
National Provider Identifier (NPI) (10-digit Billing NPI)			BCBS Provider Number (if NPI is not applicable – for example, "Atypical Provider")	
Provider Name (please print)			Federal Tax ID	
Provider Address	City		State	Zip
Provider Signature (Required)				Date

If you have any questions regarding the enrollment process you may contact Availity Client Services at (800) AVAILITY (282-4548). Return your completed, signed form via mail or fax to:

Availity
P.O. Box 833905
Richardson, TX 75098-3905
Fax: (972) 383-6450

Availity is a registered trademark of Availity, L.L.C. Availity is an independent third party vendor.

Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC) makes no endorsement, representations or warranties regarding any products or services offered by third party vendors. The vendors are solely responsible for the products or services offered by them. If you have any questions regarding any of the products or services offered by the vendor, you should contact the vendor directly.

Divisions of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association 01966.0609