

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: | | | | | |

Health-e-Web Marketing Info:

837 Claims

835 ERA

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|---|--|
| Clinic/Practice Name: | |
| Group NPI #: | |
| Federal Tax ID #: | |
| Contact Name: | |
| Address: | |
| City, State, Zip: | |
| Phone Number: | |
| Email Address: | |
| ECN/Direct Send: | Direct Send |
| Clearinghouse Name: | Emdeon |
| Contact Name & Phone Number: | ENROLLMENT HELP DESK 800-845-6592 |
| ANSI Format: | 4010A1 |
| Provider Name: | |
| Federal Tax Id #: | |
| BCBSMT #: | |
| NPI: | |
| Repeat this information for each provider: | |
| Provider Name: | |
| Federal Tax Id #: | |
| BCBSMT #: | |
| NPI: | |
| Provider Name: | |
| Federal Tax Id #: | |
| BCBSMT #: | |
| NPI: | |
| | |
| | |

Comments: