

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:					



**TRICARE
PROVIDER AUTHORIZATION FOR WPS
ELECTRONIC REMITTANCE ADVICE**

Due to privacy regulations, this request must be submitted by the provider's office or authorized billing agent.

Check all that apply:

TRICARE West Region TRICARE For Life TRICARE Overseas

The only version of electronic remittance available is 4010A1.

ERA PROVIDER INFORMATION

Provider Name: _____

PROVIDER TAX ID: _____

List below NPI's and correlating physical location requesting an electronic remittance advice (**attach additional sheet if necessary.**)

<u>NPI</u>	<u>PHYSICAL LOCATION</u>	<u>ASSOCIATED BILLING LOCATION</u>
1. _____	_____	_____
	_____	_____
	_____	_____
2. _____	_____	_____
	_____	_____
	_____	_____
3. _____	_____	_____
	_____	_____
	_____	_____
4. _____	_____	_____
	_____	_____
	_____	_____

If you add an additional service location in the future and wish to receive ERA for this new location, please contact WPS Electronic Data Services at 1-800-782-2680 or go to our EDI web site at <http://www.wpsic.com/edi/tricare.shtml> and download another form.



ERA REQUESTER INFORMATION

Requesters Contact Name: _____

Requesters Phone #/Email Address: _____

Provider Authorized Requestor Name: _____

Authorized Signature: _____ Date: _____

ERA RECEIVER INFORMATION

Who will be receiving your ERA?

Submitter #: 99053

Billing Service/Clearinghouse Name: EMDEON

Contact Name: ENROLLMENT HELP DESK

Contact Phone#: 866.924.4634

Contact Email address: PAYERREGISTRATION@EMDEON.COM

Electronic Claim Payment/Advice Receiver # (5 digit # assigned by WPS): _____

Date to begin ERA: _____

Due to HIPAA requirements, only one submitter ID per provider number may be established for ERA. The submitter ID on this request will be the only recipient of ERA for the provider(s) listed.

An original or faxed copy will be accepted. Please mail or fax your completed agreement to:

Wisconsin Physicians Service
Electronic Data Service
P.O. Box 8128
Madison, WI 53708-8128

Fax (608-) 223-3824