

PAYER ID:

SUBMITTER ID:



## Emdeon ERA Provider Information Form

\*This form is to ensure accuracy in updating the appropriate account

<b>1 Provider Organization</b>					
Practice/ Facility Name		Provider Name			
Tax ID		Client ID		Site ID	
Address		City/State		Zip Code	
Contact Name					
E-mail Address		Telephone		Fax	
<b>2 Vendor</b> <i>(Emdeon certified vendor used to submit files to Emdeon)</i>					
Vendor Name		Vendor Submitter ID		Division ID	
Contact Name					
E-mail Address					
<b>3 Payer</b>					
Payer ID					
Group ID	Individual Provider ID		NPI ID		
<b>4 Confirmations</b>					
Send Emdeon Claim Confirmations To:					
<b>Special Instructions:</b> <ul style="list-style-type: none"> <li>• All Payer Registration forms must contain original signatures, no stamped signatures or photocopies are accepted.</li> <li>• SUBMIT COMPLETED FORM TO:  Emdeon  Donelson Corporate Ctr Bldg 3  3055 Lebanon Pike Ste 1000  NASHVILLE, TN 37214-2230</li> </ul>					
ENROLLMENT FORM MUST BE PROCESSED BY EMDEON DO NOT SUBMIT DIRECT TO THE PAYER					
EMDEON REVISION FORM DATE:					



# 835 Request Or Termination Form

This form is used by providers, clearinghouses and/or billing services for purposes of establishing or terminating the 835 Electronic Remittance Advice. It is a requirement that the form be completed and signed off by representatives of *both* the provider and the clearinghouse/billing service, if applicable.

*Only one Medicaid Provider Number may be identified per form.*

## **STEP 1:**

Action (check one)     Request 835 set-up     Cancel 835 set-up     Change 835 set-up  
Set-up (check one)     835 Direct to Provider (Continue to STEP 3)  
                                   835 Direct to Clearinghouse or Billing agency (Complete STEPS 2 and 3)

**Please print legibly**

## **STEP 2:**

**To be completed by clearinghouse or billing service, if applicable:**

Date: \_\_\_\_\_    Submitter ID: 4861  
Clearinghouse Name: EMDEON  
Contact Name: ENROLLMENT HELP DESK  
Telephone Number: (866) 924-4634 EXT: \_\_\_\_\_    Fax Number: (615) 231-4843  
Clearinghouse Signature: \_\_\_\_\_  
Printed Name of Clearing House Signature: \_\_\_\_\_

## **STEP 3:**

**To be completed by provider:**

Date: \_\_\_\_\_    Submitter ID: \_\_\_\_\_    Medicaid Provider Number: \_\_\_\_\_  
Provider Name: \_\_\_\_\_  
Contact Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ EXT: \_\_\_\_\_ Fax Number: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Provider Signature: \_\_\_\_\_  
Printed Name of Provider Signature: \_\_\_\_\_

**Return by fax to EDS an HP company Electronic Commerce Services at 919-859-9703.**

## **For ECS Use only:**

MB#/Name Verification: \_\_\_\_\_    Update date: \_\_\_\_\_    Verification Date: \_\_\_\_\_  
835 TXN Verification: \_\_\_\_\_    Analyst Initials: \_\_\_\_\_    Verified By: \_\_\_\_\_