

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 					
ERA ENROLLMENT FOR PAYER ID 12K35 IS PROCESSED THROUGH PAYER ID SKNY0. PLEASE ENSURE YOU ARE SETUP FOR SKNY0 WITHIN EMDEON'S ERA SYSTEM TO RECEIVE REMITTANCE.					
EMDEON REVISION FORM DATE:					

ELECTRONIC REMITTANCE 835/820 REQUEST FORM

In order to receive the New York Medicaid remittance advice in the electronic HIPAA-compliant 835 or 820 format through eMedNY eXchange or FTP, please complete all of the following information and either mail or fax the completed form to:

Computer Sciences Corporation
Attn: Provider Enrollment Support
P.O. Box 4614
Rensselaer, New York 12144
FAX: (518) 257-4632

WARNING: YOUR SYSTEM MUST BE READY TO ACCEPT THIS FORMAT PRIOR TO REQUESTING ELECTRONIC REMITTANCES.

NOTE: YOU MUST BE ENROLLED IN EITHER EMEDNY EXCHANGE OR FTP PRIOR TO REQUESTING THE ELECTRONIC REMITTANCE ADVICE. PLEASE ENTER YOUR ASSIGNED eXchange or FTP USER ID BELOW.

1. ETIN (formerly TSN): 05L

2. PROVIDER Medicaid ID: _____ (Required)

NPI: _____ (Required, unless NPI exempt)

(For multiple provider IDs, please submit a separate list, TYPE WRITTEN IN ASCENDING ORDER, attached to this form.) Please note: If you have submitted a Certification Statement to link a provider to your ETIN, this form must also be submitted to request an electronic 835/820 remittance for each newly linked provider. (Otherwise, the default is a paper remittance.)

3. GROUP Medicaid ID: _____ (Required)

NPI: _____ (Required, unless NPI exempt) (If applicable)

(Only if billing with a Group ID. If this request is for a Group remittance, no individual Provider ID should be entered.)

4. If this is your only ETIN, the electronic remittance for this ETIN will be used for reporting paper claim forms and adjustments/voids submitted by the State. Otherwise, if you have multiple ETIN's, and want the ETIN listed above to be used for this purpose, place an "X" in this box.

(In the future, should you elect to have these types of claims sent to a different ETIN's remittance, you will need to submit another request form.)

5. ORGANIZATION NAME: _____

6. ADDRESS: _____

7. CONTACT NAME: _____

8. CONTACT PHONE #: _____

9. eMAIL ADDRESS: _____

10. FAX #: _____

ENTER YOUR ASSIGNED USER ID BELOW AND CHECK YOUR CHOSEN METHOD OF REMITTANCE RETRIEVAL (eXchange or FTP). Check paper to switch back to paper remittance.

USER ID: B547300 eXchange _____ FTP VPN paper _____

SIGNATURE: _____ DATE SIGNED: _____

SIGNED BY (PRINT NAME): _____ TITLE: _____

Please note: This form will be returned if it contains incomplete or illegible information.