

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:					

HOSPITAL, NURSING HOME/LTC, HCFA 1500, AND PHARMACY ELECTRONIC MEDIA PROVIDER AGREEMENT

Pursuant to Administrative Rule of South Dakota (67:16:35:05) this agreement is made and entered into by and between the Department of Social Services, State of South Dakota, also referred to as the "South Dakota Medical Assistance Program" and _____, also referred to as the "Provider". The purpose of this agreement is to enable the Provider to submit claims to the South Dakota Medical Assistance Program Agency with the use of electronic media.

It is hereby agreed as follows:

A. GENERAL PROVISIONS

1. This agreement will be automatically renewed for one year on July 1 if neither party gives notice requesting termination, except that the duration of this agreement may be limited pursuant to action by the South Dakota Medical Assistance Program in excluding a provider for fraud or abuse pursuant to 42 CFR Part 1002. This agreement may be voluntarily terminated by either party by giving thirty (30) days written notice to the other party.
2. This agreement may be modified in writing by mutual consent of the South Dakota Medical Assistance Program and the Provider. Any such modification shall be attached to this agreement and become a part thereof.
3. The Provider must be an authorized medical assistance provider with a signed Standard Provider Agreement on file in order to enter into this agreement.
4. This agreement will in no way supersede the Standard Provider Agreement.

B. RESPONSIBILITIES OF THE PROVIDER/BILLING AGENT

1. Claims submitted by electronic media must comply with the format specifications defined by the South Dakota Medical Assistance Program. Failure to comply with the format specifications will result in the electronic claim being rejected.
2. The provider will notify the South Dakota Medical Assistance Program if the provider changes software providers or billing agents.

C. RESPONSIBILITIES OF THE SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM

If the above mentioned requirements are met the South Dakota Medical Assistance Program shall be responsible for the following:

1. The South Dakota Medical Assistance Program will process and reimburse the Provider in a timely manner for all covered services submitted via electronic media.
2. The South Dakota Medical Assistance Program will notify the Provider/Billing Agent of any changes that may occur in the format specifications.

PROVIDER

Provider Type: HCFA Hospital Pharmacy Nursing Home/LTC

How are you submitting? Modem POS Launch Pad/Web Application

Provider Name (Typed)

Provider Number

Authorized Signature

Tax ID Number

Contact Person (Typed)

Telephone Number

Title (Typed)

Date



SOFTWARE PROVIDER OR BILLING AGENCY

Emdeon
Billing Agency or Software Name

111111249
Billing Agency or Software Number

26 Century Blvd, Suite 601

Nashville, TN 37214

Street Address

City, State and Zip Code

Enrollment Help Desk

800-845-6592

Contact Person (Typed)

Telephone Number

Electronic Remit YES NO

277 Claim Status Response YES NO

Start Date _____

Start Date _____



SOUTH DAKOTA MEDICAL ASSISTANCE PROGRAM

Approved By: _____
Larry Iversen, Division Director

Date