

PAYER ID:

SUBMITTER ID:



emdeon™

## 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:					
Special Instructions:					
<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>					
EMDEON REVISION FORM DATE:					



RHODE ISLAND DEPARTMENT OF HUMAN SERVICES



## Trading Partner Agreement ID Change/Add form

Once a Trading Partner Agreement (TPA) is received and processed, this form may be used to add additional billing providers to the original TPA ID assigned. This form must be received with original signatures. **No facsimile or photocopies will be accepted.**

Trading Partner Name: Emdeon

Assigned Trading Partner ID: 601200004

Before mailing your signed Trading Partner Agreement to EDS for processing please verify that:

- The document is complete
- Signatures are in the appropriate areas
- You have checked the transactions that you will be submitting and receiving (See page 5 of the TPA)



**ARTICLE II. RHODE ISLAND MEDICAL ASSISTANCE PROVIDERS**

Please list the names and the RI Medical Assistance Program provider numbers of those providers for which electronic transactions will be submitted. Each individual provider or group for whom you will be billing must sign and date the agreement below. If additional space is required to identify each provider make copies of Article II and attach.

1. \_\_\_\_\_  
Medical Assistance Provider Number

Provider Name: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_

2. \_\_\_\_\_  
Medical Assistance Provider Number

Provider Name: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_

3. \_\_\_\_\_  
Medical Assistance Provider Number

Provider Name: \_\_\_\_\_

Authorized Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**Trading Partner Execution:  
TRADING PARTNER**

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Signed

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Name

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Title

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**DO NOT FAX**

**Please mail this certification to the  
Following address:**

**EDS  
Attn: EDI  
171 Service Avenue  
Building 1, Suite 100  
Warwick, RI 02866**