

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 #: 11722

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