

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/FACILITY NAME: _____

*PROVIDER/FACILITY TAX ID: _____

List below NPI's and correlating physical location requesting an electronic remittance advice (**attach additional sheet if necessary.**)

<u>GROUP 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, go to our EDI web site at <http://www.wpsic.com/edi/tricare.shtml> and download another form.

*REQUIRED



ERA REQUESTER INFORMATION

*Requesters Contact Name: _____
*Requesters Phone #/Email Address: _____
*Provider Authorized Requestor Name: _____
*Authorized Signature: _____ *Date: _____

ERA RECEIVER INFORMATION

Who submits your EDI claims?

Submitter #: 11722

Who will be receiving your ERAs?

*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): _____

If you don't know your Clearinghouse Receiver ID, contact your Clearinghouse.

If you don't use a Clearinghouse and you don't know your submitter ID, Contact 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

***REQUIRED**