

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:					

**INSTRUCTIONS FOR COMPLETING THE AUTHORIZATION AGREEMENT FOR
ELECTRONIC EXPLANATION OF PAYMENT AND/OR DIRECT DEPOSIT OF PAYMENTS**

SECTION 1 – EOP

1. Enter “X” to indicate the type of transaction:
‘Add’ indicates a new authorization
‘Change’ indicates a change to an existing authorization
‘Delete’ indicates a request for termination of authorization.
Enter “X” to indicate if this agreement is for the electronic EOP request or both EOP & EFT.
Complete section 1 only, if this is an 835 EOP Request. Complete Sections 1 & 2 if this is for EOP & EFT.
2. Enter the complete name and address of the company or individual participating in the EOP/EFT program. Circle Y or N to indicate if there are multiple billing addresses for this Federal Tax Identification/Social Security #.
3. Enter your company’s Federal Tax Identification number or your Social Security # if you, as an individual are participating. Enter your receiver id number. Indicate whether you will receive the EOP/EFT direct from NHP or via Emdeon.
4. **If application is NOT for an individual, the name and official title of the highest-ranking officer of the company must be provided. The application will not be processed without this information.**

SECTION 2 - EFT

If you are requesting the EFT, please complete this section in addition to the information provided in Section 1.

1. Enter the name and address of the ACH member financial institution authorized to conduct transaction. The requirement of the Uniform Depository Act, Chapter 135 of the Ohio Revised Code, is applicable to EFT banking transactions.
2. Enter the financial institution’s Transit Routing/ABA number in the spaces provided. This is a nine-digit number that is shown on your check. It may also be obtained by contacting your financial institution and requesting its Transit Routing/ABA number.
3. Enter the account number to which the EFT transactions are to be accredited. If less than 17 characters are needed, begin at the left margin and leave any unused spaces blank. Mark an “X” for the type of account to which funds are to be deposited. ***

***If you elect to deposit in a checking account, please attach one of your checks with the signature space marked “void”.

Forward the signed authorization form with voided check (if applicable) to:

Nationwide Health Plans
Provider Maintenance Dept. – CO-02-40
5525 Park Center Circle
Dublin, OH 43017
614-854-3810 (fax)

If you have any questions, contact the Provider Maintenance department at 1-800-372-0713 opt.7 or 1-800-566-2491 or email us at NHPPROSR@Nationwide.Com.

