

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 					
<p>Payer can no longer process EFT requests without a voided check (no deposit slips please). Payer requires the ABA number from the voided check. EFT's fail with the deposit slip ABA numbers.</p>					
EMDEON REVISION FORM DATE:					



ERA Enrollment Form

Please Fax or E-mail Completed Forms to:
Fax: (818) 234-9966
EDIENROLL-CA@Wellpoint.com
Anthem Blue Cross
ATTN: EDI Solutions CAAC07-077B
PO Box 4173, Woodland Hills, CA 91365-4173
EDI Technical Support: (800) 227-3983

Incomplete enrollment packages will be returned unprocessed

Please print clearly. A separate form is required for each Tax Identification Number.

Provider Name: _____

Tax ID #: _____ NPI #: _____ Medicare #: _____

Physical Address: _____ City: _____ State: _____ ZIP: _____

Contact Name: _____ Title: _____

Email: _____ Phone: _____ Fax: _____

Please indicate method of retrieval for your Anthem Blue Cross Electronic Remittance Advice (ERA) file:

- We are a direct claim submitter and will download our own ERA files.
Our electronic mailbox ID is (ex: ZHCQ0000) _____
Our ERA translation software is _____
- Please assign a new mailbox to download our own ERA files.
Our ERA translation software is _____
- We are switching vendors. Please discontinue our current ERA services with vendor: _____
- Our vendor will retrieve all ERA files for us. (Please have vendor complete the following fields.)

Vendor Name: EMDEON

Vendor Contact Name: ENROLLMENT HELP DESK

Vendor Contact Phone: 800-845-6592

Vendor Email: PAYERREGISTRATION@EMDEON.COM

Note: Please make sure vendor is set up to receive ERA files from Blue Cross of California. We can not process this request if they are not set up.

A Company Officer must sign this form. This is a legal document

PRINT NAME: _____ SIGNATURE: _____

TITLE: _____ DATE: _____ PHONE: _____



EFT Enrollment Form

Please Fax or E-mail Completed Forms to:
Fax: (818) 234-9966
EDIENROLL-CA@Wellpoint.com
Anthem Blue Cross
ATTN: EDI Solutions CAAC07-077B
PO Box 4173, Woodland Hills, CA 91365-4173
EDI Technical Support: (800) 227-3983

Incomplete enrollment packages will be returned unprocessed

Anthem Blue Cross Systems is hereby authorized to deposit payments for claims to the account listed below.
A voided blank check or bank authorization letter is required for the account receiving the direct deposit.

DEPOSIT SLIPS ARE NOT ACCEPTED UNDER ANY CIRCUMSTANCES.

PROVIDER NAME (REQUIRED)		MEDICARE PROVIDER NUMBER (REQUIRED)	
ADMINISTRATIVE CONTACT: (REQUIRED)		TAX ID NUMBER: (REQUIRED)	
TITLE: (REQUIRED)		PHONE NUMBER: (REQUIRED)	

BANK INFORMATION

NAME ON BANK ACCOUNT (REQUIRED)			
ACCOUNT TYPE (REQUIRED) <input type="checkbox"/> CHECKING <input type="checkbox"/> SAVINGS			
BANK NAME (REQUIRED)		BRANCH NAME (REQUIRED)	
COMPLETE BANK ADDRESS (REQUIRED) Address1 Address2 City, St, ZIP		BANK PHONE NUMBER (REQUIRED)	
ACCOUNT NUMBER (REQUIRED) Must match letter or voided Check		TRANSIT/ABA NUMBER (REQUIRED) Must match letter or voided Check	

An authorized signer on the bank account must sign this form
This is a legal document.

PRINT NAME: (REQUIRED)	_____	SIGNATURE: (REQUIRED)	_____
TITLE: (REQUIRED)	_____	PHONE NUMBER: (REQUIRED)	_____
DATE SIGNED: (REQUIRED)	_____	FAX NUMBER:	_____

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ATTACHMENT B